Psychologists' Practices, Training, and Experiences Conducting Suicide Risk Assessment in Canada: An Explanatory Sequential Mixed Methods Study

by

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Abstract

Over the last 10 years, suicide prevention best practices have changed. We have learned that suicide cannot be reliably predicted, that hospitalizations for acute suicidality are harmful, and treating suicidal behaviours only has a small effect size. As a result, collaborative and humanistic models of suicide risk assessment (SRA) are indicated, with a priority on understanding and treating the idiographic drivers of the client's suicidality. Understanding if these changes have been incorporated into psychologists' practice is essential, given SRA training has historically taught information-focused and risk-based assessments, where prediction was prioritized over prevention.

The purpose of this study was to understand how, or if, psychologists in Canada have been incorporating this information into their practice, as well as more broadly understanding how they learn and experience the process of suicide risk assessment (SRA). To do this, I used a sequential explanatory mixed methods approach, which integrates both quantitative and qualitative methods to explore and explain research findings. One-hundred and sixty psychologists completed a survey on their SRA practices, training, and experiences, and I conducted nine follow-up interviews asking them to elaborate and explain their survey answers. The survey results were analyzed using descriptive statistics whereas the interview results were analyzed with a co-investigator using both Thematic Analysis (bottom-up) and Rapid Assessment Process (top-down). Together, we integrated both the quantitative and qualitative strands into conclusions that answered our main research questions: How do psychologists in Canada (a) practice, (b) learn, and (c) experience SRA, as well as (d) how do the interviews explain the survey results?

Regarding (a) SRA practice, psychologists in Canada conduct idiosyncratically structured and risk focused SRAs, where their priority is ensuring their client's safety. These SRAs are a medley of practices they've acquired throughout their training and experiences, with the heaviest influence coming from their practicum or internship supervisors. Those who use standardized SRAs usually do so because of

work or institutional requirements, whereas those who use personalized SRAs believe standardized SRAs disrupt the therapeutic relationship. Psychologists are confident in their SRA practices, identifying that this process took years of post-graduate experience. They also understand hospitalization as a harmful last resort but will not hesitate to make a confidentiality- or alliance-breaking referral if it means keeping their client safe. Regarding learning SRA, (b) psychologists resoundingly report their graduate SRA training was insufficient and inefficient, as the lack of practicable and experiential training limited their confidence and competence when working with suicidal clients. As such, psychologists support SRA and crisis management as a core competency in graduate training. Concerning (c) SRA experiences, psychologists understand suicidality is a psychosocial issue, typically resulting in the hopeless belief that the pain will never end, yet, more than half of psychologists do not ask about what drives their client's suicidal ideation. Psychologists reported that working with a suicidal client is more stressful than working with others because of the conflict between feeling responsible for their safety and maintaining their clients' autonomy and dignity. Accordingly, most psychologists fear the legal or professional consequences of an improper SRA and use SRAs to mitigate their legal vulnerability. The (d) interviews explained several of the survey results, resulting in these integrated findings.

This broad and deep understanding of psychologists' SRA practices, training, and experiences offers critical insights into how we can implement findings from the last 10 years into routine care. This includes promoting collaborative and therapeutic SRAs in practice, incorporating experiential graduate training, focusing on training supervisors to teach SRA, and integrating suicide prevention as a core competency for CPA-accredited programs. Other implications for practice, training, and policy are discussed, including future directions and limitations.

Preface

This thesis is an original work by Jonathan Dubue. It received research ethics approval from the University of Alberta Research Ethics Board 2, Project Name: “Psychologists’ Practices and Experiences Conducting Suicide Risk Assessment in Canada: An Explanatory Sequential Mixed Methods Study”, ID No. Pro00105480, November 24, 2020. No part of it has been published previously.

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Chapter I: Introduction

Over the last 10 years, our understanding, treatment, and prevention of suicide has undergone a paradigmatic shift. Axiomatic practices such as assessing risk have been shown to contribute little to suicide prediction (Chan et al., 2016; Franklin et al., 2017; Large et al., 2016; Large & Ryan, 2014b), hospitalization for acute suicide may have iatrogenic harm (Large et al., 2011; Ward-Ciesielski & Rizvi, 2020), universal screening is too sensitive and offers little clinical value (Kessler et al., 2020; Nestadt et al., 2020), and clients report that formulaic assessments can damage the therapeutic alliance (Deering et al., 2019; Richards et al., 2019; Xanthopoulou et al., 2022). We are questioning our most basic assumptions that suicide is predictable and preventable, with recent findings concluding that we are only slightly better than chance at predicting suicide (Franklin et al., 2017) and that zero-suicide initiatives are unfoundedly optimistic (Cannon & Hudzik, 2014; Nestadt et al., 2020; Schwartz-lifshitz et al., 2012; Walter & Pridmore, 2012). This knowledge comes off the back of a rapidly growing literature, as the number of publications in suicidology has multiplied by 6 annually across the last 30 years, a trend that has outpaced research in most mental health fields (Astraud et al., 2020). The result is a zeitgeist that is no longer focused on prediction, but rather, prevention. Now, novel suicide theory is used primarily to guide intervention, focusing on understanding suicide rather than predicting it (Klonsky, 2020; Klonsky & May, 2015), risk assessments are designed to be collaborative, therapeutic, and flexible (Fortune & Hetrick, 2022; Hawton et al., 2022; Jobes, 2020; Large, 2018; Lucey & Matti, 2021), and safety plans are increasingly client-centered, designed to build hope, bolster emotional regulation, and avoid paternalistic intervention that undermine autonomy (Ferguson et al., 2022; Hawton et al., 2022; Jobes, 2020; M. Smith, 2022).

How we understand, treat, and prevent suicide has changed, yet we do not know how, or if, this knowledge has been translated to psychologists' practice. To better understand these changes, I review (a) the problems with predicting suicide, (b) the case for focusing on prevention, and (c) the impact of

suicide risk assessment on clinicians and clients. Next, I preview (d) the present study, (e) its significance, and (f) relevance to counselling psychology, which frames this study's main research question: how do psychologists in Canada practice, learn, and experience suicide risk assessment?

The Problems with Predicting Suicide

The change in suicide practice is happening, in part, because of suicidology's problematic and inordinate interest in prediction. For over 60 years (Rosen, 1954) we have wrestled with the ethos that suicide is a prediction problem, and better prediction means better prevention (Belsher et al., 2019; McKernan et al., 2018; Miché et al., 2020; Nielssen et al., 2017). Klonsky (2021) even points out that the most cited paper in suicidology of the last 5 years is Franklin and colleagues' (2017) meta-analysis concluding we are only slightly better than chance at predicting suicide, whereas the most cited papers in other health fields are on basic statistics or interventions. Yet, despite these decades of research advancing our knowledge of risk factors, processes of self-harm, and prolific scale and checklist development, our suicide rates remain globally stagnant and we have made no appreciable gain in predicting who will self-harm or die by suicide (Chan et al., 2016; Franklin et al., 2017; Large et al., 2016; Woodford et al., 2019). The tool most often used to assess suicide is called a suicide risk assessment (SRA). Graney and colleagues (2020) found that SRAs are predominately used to predict self-harm and suicide behaviour (99% of the time), the scores of which are used to determine risk management decisions (94% of the time). A systematic review of SRA scales and measures found the pooled positive predictive value (PPV) of suicide is 5.5%, which, said differently, suggests our best measures only accurately identify 1 in every 20 people who are at risk of death by suicide (Carter et al., 2017). Not only are we poor predicters, but we simultaneously both minimize and overestimate actual risk; a meta-analysis reviewing 40 years of risk assessment data found 55% of deaths by suicide occur in those deemed low-risk and 95% of those deemed high risk do not die by suicide (Large et al., 2016). To date, SRAs have not demonstrably helped us predict suicide.

The misclassification of suicide risk is not just a prediction problem, but also a humanitarian one. Those falsely categorized as low risk get limited access to treatment which risks increasing maladaptive coping (e.g., self-harm, substance misuse) (Sutherland, 2021). Furthermore, their distress is invalidated, causing iatrogenic harm and decreasing the likelihood they will reach out again (Bellairs-Walsh et al., 2020). The opposite is also true, where those falsely deemed high-risk can be involuntarily hospitalized, an autonomy-restricting experience that paradoxically increases suicide risk among other harms (Harris & Goh, 2017; Large et al., 2014; Ward-Ciesielski & Rizvi, 2020). These misclassifications are magnified with health care policies that universally assess for risk; not only do universal screens of suicide get it wrong most of the time, they also systematically undermine autonomy and cause direct harm from coercive intervention (Kessler et al., 2020; M. Smith, 2022). Despite our best attempts at prediction, contemporary evidence concludes that there is no clear benefit to attempting to predict suicide risk, while there is significant risk of harm.

Recent novelties also show little promise. Machine learning algorithms, which utilize big data to develop complex models between risk and protective factors, often outperform the linear models typically employed by SRA researchers (Kessler et al., 2020; Passos et al., 2019). However, recent evidence suggests these predictive values are greatly inflated to the point of insignificance (Jacobucci et al., 2021) and that these machine learning approaches would, even if predictive, be difficult to implement into routine clinical practice (Belsher et al., 2019). Unassisted clinician SRA, that is, SRA that forgoes scales or measures in favour of a risk stratifying clinical interview, have also demonstrated low PPV. In their systematic review, Woodford and colleagues (2019) found high-risk classifications for repeated self-harm would be incorrect nearly 80% of the time, making these assessments clinically useless. Other evidence also concluded that unstructured SRAs are no better predictors than social, historical, or clinical variables (Large et al., 2011)**.** Even when stripping down our SRAs to focus exclusively on using suicidal ideation to predict later suicide, McHugh and colleagues (2019) only found a

moderate association in their meta-analysis, which they warn should be interpreted cautiously given the large and unexplained heterogeneity between studies.

All these approaches struggle with finding predictive validity for two main reasons: (a) suicidality fluctuates faster than we typically measure it and (b) machine learning approaches neglect best practices. Mapping the timescale of suicidal thinking has long eluded suicidologists, but with the advent of ecological momentary assessment (EMA) facilitators, such as smartwatches and smartphones, we now have a clear understanding that suicidal thinking changes quickly. Coppersmith and colleagues (2022) found that suicidal thoughts last on average between 1 to 3 hours, that suicidal desire often precedes and lasts longer than intent, and there is considerable heterogeneity in the length and frequency of suicidal thoughts (Coppersmith et al., 2022). Their models also demonstrate that suicide desire is only relatively predictive of intent for around 2 to 3 hours, suggesting that one-time, or weekly, SRAs are missing the dynamic process that unfolds over a short time window. This is somewhat consistent with other evidence demonstrating that nearly half of clients who attempted suicide had only thought about the act for 10 minutes or less beforehand (Deisenhammer et al., 2009). Secondly, Kessler and colleagues (2020) argue that machine learning approaches are usually only applied to one data set thereby failing to cross-validate, have not yet improved prediction by combining multiple algorithms into an ensemble, and continue to use imbalanced data sets, that is, data sets where there are few positive cases (e.g., deaths by suicide). Although the former two are methodological, the latter is a base rate problem, which as Rosen (1954) first pointed out, is the fundamental problem of suicide prediction. Although it is a devastating public health concern, suicide is relatively rare, with only 0.01% dying by suicide annually in Canada (Statistics Canada, 2017). Even our most predictive risk factor, a previous suicide attempt that increases the risk of death by 30 times, only increases the base rate to 0.35%, which is still very rare. However, even if these problems in machine learning are rectified, there remains the chasm between prediction and useful clinical practice (Kessler et al., 2020). Suicide prediction has

been extensively tried (Franklin et al., 2017; Kessler et al., 2020) and even with dynamic and multifaceted advents, we are no closer to reliably knowing who will die by suicide.

The Case for Suicide Prevention

Prediction is, however, not the end goal of suicidology; it's prevention. When investigating other health issues, such as heart disease, prediction is equally poor (Weng et al., 2017), yet there has been a 70% reduction in mortality in the last three decades (Mensah et al., 2017). This is true of other public health issues, such as stroke (Béjot et al., 2016), firearm violence (Wintemute, 2015), and drunk driving accidents (Fell et al., 2020). Even if we could predict suicide with 100% accuracy, our best prevention efforts do not benefit; suicide is often best prevented with a systemic limitation of lethal means (e.g., firearm restriction, bridge safety nets, reducing rooftop access) (Boggs et al., 2020; I. H. Stanley et al., 2020; Zalsman et al., 2016) which can be done without knowing who will attempt. Admittedly, it is also important to note that suicide is more difficult to prevent compared to other public health problems: (a) the base rate of suicide is very low so proportional decreases may not appear as significant (e.g., for each suicide there are 27 drunk driving accidents; Statistics Canada, 2015, 2017), (b) deinstitutionalization forced suicide treatment on communities and the individual, whereas most other health issues are treated at the institutional level (Sealy & Whitehead, 2004; Shen & Snowden, 2014), and (c) suicide continues to be stigmatized, limiting the likelihood of seeking treatment or receiving institutional support (Xu et al., 2018). However, it is clear successful prevention of other health issues is possible without prediction and that perfect prediction of suicide may not dramatically help its prevention.

Nevertheless, most clinicians care to prevent suicide at the individual level. Jobes and colleagues (2015) reported that we have well-studied, suicide-specific interventions with replicated randomized controlled trials (RCTs) such as Dialectical Behavior Therapy (DBT), Cognitive Therapy for Suicide Prevention, the Collaborative Assessment and Management of Suicidality (CAMS), and a "caring

contact" follow-up. These interventions have reliably and significantly reduced suicide behaviours, such as self-harm, and concurrently treat the client's distress. In a systematic review and meta-analysis of studies evaluating suicide prevention interventions between 2011 and 2017, Hofstra and colleagues (2020) found a significant effect on reducing deaths by suicide (d = 0.5) and suicide attempts (d = 0.5), with higher effectiveness in studies that had multi-level interventions (e.g., clinician intervention combined with a health authority prevention campaign).

However, recent evidence has brought this effectiveness into question. Between 2020 and 2021 alone, six meta-analytic and three systematic narrative reviews of RCTs examining interventions that reduce self-injurious thoughts and behaviours (SITBs) were published (Kleiman et al., 2022). The most comprehensive of these reviews looked at 591 articles that compiled 1,125 RTCs, detailing 3,458 effect sizes from over 50 years of suicide intervention literature, where they found that intervention effects for addressing SITBs were small and have not improved over time (Fox et al., 2020). That is, on average, treatments reduced suicidal ideation and behaviours by 9% compared to controls, a finding that is generally consistent with the other meta-analyses and reviews (Zalsman et al., 2016). In interpreting these findings, both Kessler and colleagues (2020) and Kleiman and colleagues (2022) identified the small effect size could be explained by the heterogeneity of SITB interventions. Kessler and colleagues (2020) note that suicide is often treated concurrently with mental disorders in which, despite sharing some similarities, there are meaningful differences in their causal factors. Further, some of the suicide-specific interventions typically focus on intermediate outcomes, such as emotional regulation or cognitive distortions, not on reducing suicide behaviour or ideation. As well, the etiologies of suicide are diverse, which is statistically problematic, likely diluting aggregate effects and may be poorly treated by fixed nomothetic interventions. Kleiman and colleagues (2022) summarize the key limitation of these meta-analyses by identifying that they did not include idiographic models of suicide prevention, that is, interventions that focus on the unique conditions and drivers of that client's suicidality.

One such idiographic model that Kleiman and colleagues (2022) argues has shown promise is CAMS (Jobes, 2012). CAMS focuses on treating the idiosyncratic drivers of suicide (e.g., general hopelessness, interpersonal relationship concerns) while using standardized scales and flexible manualized interventions. Ideally, this collaborative, yet consistent, approach buffers against the difficulties of studying suicide interventions by being adaptable and specific to treating the vast reasons why someone thinks of suicide. Swift and colleagues (2021) tested this assumption in a recent meta-analysis on the effectiveness of CAMS. They reported a course of CAMS (i.e., 16 sessions) significantly reduces suicidal ideation (d=0.25) and general distress (d=0.29), and significantly increases treatment acceptability (d=0.42) and hope (d=0.88) compared to treatment as usual (TAU). This driver-focused treatment is also lauded as effective by clients, as they rate the focus on the problems that cause their suicidality more valuable than risk assessment and monitoring (Schembari et al., 2016).

Both Kleiman and colleagues (2022) and Hofstra and colleagues (2020) also note the meta-analyses do not recognize how multi-component and multi-level interventions are complementary and effective, the safety plan being a principal example. The purpose of a safety plan is to reduce the imminent suicidal behaviours by developing a set of coping strategies, listing personalized resources, and identifying alternative behaviours that are accessible by the suicidal client (B. Stanley & Brown, 2012). This practice has become an integral part of suicide prevention efforts and has been used even as a standalone intervention (Ferguson et al., 2022; B. Stanley & Brown, 2012). In their meta-analysis of studies examining safety plan effectiveness, Nuij and colleagues (2021) found safety planning results in a significant 43% decrease in suicide behaviours, but found no difference in suicidal ideation, compared to TAU. Similarly, in a systematic review of the same literature, Ferguson and colleagues (2022) concluded that safety planning appears to decrease suicide behaviour, sometimes decreases ideation, but, so far, has not shown to decrease suicide deaths. They also found that, in some cases, safety planning reduced the incidence of hospital admission or decreased the length of stay, and that most service users found

safety planning effective and helpful in getting them to manage their own suicidality. Safety plans are widely recommended for suicide prevention and, to date, demonstrate both clinical effectiveness without undermining client autonomy (Hawton et al., 2022; Jobes, 2020).

It is also important to note that some interventions that we consider preventative risk more harm and paradoxically increase suicide risk. As previously mentioned, inpatient hospitalization risks iatrogenic harm due the invalidating and vulnerable hospital milieu (Large et al., 2011; Ward-Ciesielski & Rizvi, 2020), compromises client autonomy and liberty (McKernan et al., 2018), and harms the therapeutic alliance (Hom et al., 2019; Siegel, 1979), all of which can lead to mistrust in mental health clinicians and less help-seeking behaviour in the future (Jones et al., 2021). This is corroborated by Aboussouan and colleagues' (2022) recent inquiry into the treatment received by suicidal patients in hospital, where they found over 50% reported treatment was "very unhelpful" to "somewhat unhelpful". These harms and risks may be warranted if hospitalization benefited clients, yet compared to outpatient treatment, hospitalization after a suicide attempt was no more likely to prevent a subsequent death by suicide (Steeg et al., 2018) and, in another study, was found to increase the risk of continued suicide behaviours for up to a year (Ichimura et al., 2019). This is unsurprising, in part, because hospitals do not typically have the resources to treat the psychosocial drivers of suicidality (e.g., interpersonal issues), which most people who report to hospital emergency departments cite as their main concern (Fawcett & O'Reilly, 2022). Hospital emergency departments remain an effective intervention for preventing an imminent suicide attempt but may leave the client feeling more suicidal than when they were admitted.

Another paradoxical suicide prevention intervention is the no-suicide contract (NSC). These verbal or written agreements between the client and clinician typically ask that if the client were to engage in suicide behaviours that they instead engage in their safety plan or connect with emergency services (Weiss, 2001). Other common elements include: (a) an explicit statement where clients agree

they will not kill themselves, (b) specific details about the duration of the agreement, (c) a contingency or safety plan, and (d) the clients and clinician's responsibilities (Rudd et al., 2006). The practice of NSCs, first discussed by Ewalt (1967) and later defined by Drye and colleagues (1973), was founded exclusively on anecdotes; Drye and colleagues (1973) supported NSC effectiveness by saying that in over 600 cases where they used NSCs, they never experienced a client suicide. Other evidence, conducted with more rigor, finds NSCs ineffective. Drew (2001) conducted a retrospective review of hospital medical records and compared one hospital who used NSCs to another not using them, finding that the incidence of self-harm was five times higher in the NSC-using hospital. Mishara and Daigle (1997), in a Canadian study of telephone suicide prevention centers, found that self-harm occurred in 284 out of 617 cases (46%) where NSCs were used. Not only are NSCs ineffective, but they also risk harming the client. Edwards and Sachmann (2010) found that mental health clinicians used NSCs coercively with the intent of deterring specific suicidal behaviour and for legal protection. They note that this clinician-centered practice is not only in opposition to clinical recommendations, but is also consistent with the evidence that clients find themselves disenfranchised when NSCs are used (S. E. Davis et al., 2002). Although there may have been a special ingredient used by Drye and colleagues (1973) in their NSC practice, it is clear this did not scale. Our best evidence on NSCs suggest they are ineffective in preventing self-harm, suicidal ideation, or suicide attempts, and risk harming the client and the therapeutic relationship (McMyler & Pryimachuk, 2008).

Although the literature in suicide prevention continues to develop, it is increasingly clear that what makes contemporary suicide prevention effective is idiosyncratic, collaborative, and dignifying treatment (Hawton et al., 2022; Hofstra et al., 2020; Nuij et al., 2021; Regehr et al., 2022a; M. Smith, 2022). This is consistent with recent evidence conducted in an Albertan psychiatric hospital, finding that hospital experiences that satisfy, rather than frustrate, client needs means better client attitudes towards services, more adaptive illness identification, and greater well-being (Gaine et al., 2021a). A

qualitative follow-up found that clients felt less autonomous or competent when the hospital engaged in restraining or unpleasant practices (Gaine et al., 2021b). Both findings are supportive of the long-standing theory of self-determination, which posits that when our social environment supports our psychological needs of autonomy, competence, and relatedness, we are more likely to recover and grow (Mancini, 2008; Ryan & Deci, 2000). It is perhaps no surprise that suicide prevention strategies that promote client choice and initiative (Deci et al., 1994), give structure and psychoeducation (Jang et al., 2010), and prioritize connection and the therapeutic alliance (Grolnick & Ryan, 1989) are successful in preventing suicide and reducing suicide-related distress (Allen et al., 2019; R. M. Hill & Pettit, 2013; Ryan & Deci, 2017; Sommers-Flanagan, 2019). This is suicidology's most cogent change in the last 10 years, as we appear to be transitioning from autonomy-restricting predictive practices to client-centered prevention practices (Hawton et al., 2022).

The Impact of Suicide Risk Assessment on Clinicians and Clients

This transition to client-centered prevention, for many, will not be easy. Clinicians believe SRAs provide a risk stratification that relieves uncertainty about how to intervene, offering a semblance of control that can mask the inherent anxiety and dysregulation that comes when working with a suicidal client (Hannah-Moffat et al., 2009; M. J. Smith et al., 2015). Consequently, SRAs are also the most stressful and challenging responsibility of mental health clinicians (Maris, 2019; Shea, 1999), often due to lacking time, believing nothing can be done, and fearing litigation (Ellis & Patel, 2012; Reeves & Mintz, 2001). Given the existential nature of suicide, clinicians further risk debilitating death anxiety when treating suicide-related trauma (Cureton & Clemens, 2015), often fearing how they will cope from their client's death (Pope & Tabachnick, 1993). My own qualitative inquiry found psychologists endorsing a suicide prevention practice that was driven by fear of legal and professional consequences, as they reported experiencing a culture of surveillance and used SRAs to rationalize their autonomy-limiting suicide prevention interventions (Dubue & Hanson, 2020). Some elect to avoid the suicidality altogether,

as a study of clinicians' SRAs found they asked leading questions that invited a negative response, swiftly following it with a change of topic (McCabe et al., 2017). Some psychologists cope with the emotional aspects of SRA by collaborating with peers and clients, a process some psychologists endorsed as more effective than other coping strategies (e.g., exercise, hobbies, familial support; Hopple & Ball, 2022). SRAs are a stressful and anxiogenic practice, partly due to the lack of sufficient training, which is an unfortunately common experience among clinicians (Audouard-Marzin et al., 2019; Cramer et al., 2013; Dubue & Hanson, 2020; Jahn et al., 2016, 2017; Jobes, 2020; Sommers-Flanagan & Shaw, 2017).

Clients, too, have problems with SRA. Although asking if someone is suicidal is not harmful (Harris & Goh, 2017; Polihronis et al., 2022), clients find formulaic, scripted, or structured assessments unhelpful and inauthentic (Deering et al., 2019; Richards et al., 2019; Xanthopoulou et al., 2022). This inherent harm to the therapeutic alliance is less about what is said, and more about the missed opportunity to connect with what is, for many, the most difficult admission they have made (Deering et al., 2019). Clients wished for unscripted conversations, warmth that promoted disclosure, an exploration of feelings, a validation of their distress, and a collaboratively developed safety plan (Xanthopoulou et al., 2022). This missed opportunity is also not innocuous. Negative experiences with SRA risk future self-harm, non-compliance with treatment, and a decreased likelihood of future reporting (Deering et al., 2019). Some clients also withhold or minimize their suicidality because they fear hospitalization and being stigmatized by their healthcare providers (Richards et al., 2019). Indeed, 70% of suicidal ideation concealers revealed they stayed silent about their risk because they feared involuntary hospitalization, with nearly half suggesting they would be more honest if the threat of hospitalization is reduced or controlled (Blanchard & Farber, 2020). This effect can even be found in research studies, such as Bloch-Elkouby and colleagues' (2022) finding that clients were more likely to disclose their suicidal ideation to research assistants (10.4%) than clinicians (5.6%), because they feared the loss of autonomy or

judgement from the clinician. Our tendency to practice autonomy-restrictive SRAs to reduce our fear of liability directly impacts our connection to our clients at a time where connection is vital.

The Present Study

Although there is still much to uncover, the past decade has been monumental for SRA and management research. Clinicians who have kept up with recent findings may have learned to practice more ethical and effective SRAs, diminish their own liability anxiety, and help clients better understand and manage their suicidal ideation and behaviours. However, we currently have little research showing how, or if, this knowledge is being incorporated into practice. In reviewing standards of care for suicidal risk, Jobes (2020) highlights this as one of suicidology's main issues; there is a sizable disconnect between what are best SRA practices and what is routine clinical practice. Bridging this gap is a fundamental activity for scientist-practitioners, a model that emphasizes how practice should be empirically-based and routinely updated according to novel academic findings (Blair, 2010; Ridley & Laird, 2015). In SRA, we are missing a critical piece of the scientist-practitioner feedback loop, in that we have little evidence that best practices are being practiced, which undoubtedly impacts our effectiveness research. By studying how clinicians, specifically psychologists, practice SRA, we stand to improve training, update practices, and better serve those with suicidal ideation.

The purpose of this study is to explore and explain how psychologists practice, learn, and experience SRA in Canada. To do this, I conducted a national survey on psychologists' SRA practices, training, and experiences with follow-up phone interviews with a representative sample to help explain the survey results. My research questions are:

(1) What are psychologists' practices of SRA?

(2) How are psychologists trained in SRA?

(3) How do psychologists experience SRAs?

(4) How do the interviews explain the survey results?

One hundred sixty registered or licensed psychologists across Canada completed the survey, and nine of these participants completed a 30-minute follow-up phone interview. The study followed a mixed methods design known as sequential explanatory mixed methods, where quantitative data is collected and then follow-up qualitative data is used to help explain the quantitative results.

Sequential Explanatory Mixed Method Design

The core characteristics of Mixed Method Research (MMR), according to Creswell and Plano Clark (2018), include the collection and analysis of both quantitative and qualitative data, some integration of these data, a logical organization of how these data are collected, and a framing of these procedures within theory and philosophy. Across this and other definitions of MMR, the most important and unique part of MMR is integration (Bryman, 2007). Integration is a back-and forth examination of how two or more data strands (e.g., quantitative survey and qualitative interviews) complement and contradict each other, enabling inferences that extend beyond the sum of their individual parts (e.g., 1+1=3) (Fetters & Freshwater, 2015). Integration, in this way, allows for the examination of complex phenomena where the data strands may be measuring different constructs that do not fit within one epistemological net: "what if one method captures the 'ears of the elephant' and another… 'the tail of a mouse'?'" (Uprichard & Dawney, 2019, p. 22). By collecting divergent data, mixed method researchers synthesize data into consistent findings and answer the question "what evidence is there to suggest that the object of study is not complex, multiple, and messy?" (Uprichard & Dawney, 2019, p. 28). Ultimately, MMR provides researchers with procedures to more broadly and deeply examine phenomena, often through pragmatic and constructivist worldviews (R. B. Johnson & Onwuegbuzie, 2004; Tashakkori & Teddlie, 2010).

Although recent advances call for complexity in MMR designs (Poth, 2018), most mixed method researchers adhere to a typology, or "core", design (Creswell & Plano Clark, 2018). The three core designs are differentiated by how the quantitative and qualitative data strands are sequenced, such that

they are collected at the same time (convergent) or one before the other (explanatory or exploratory sequential). For this study, I have chosen an explanatory sequential design. Here, researchers collect and analyze quantitative data, use those results to rationalize the sampling and collection of the qualitative phase, collect and analyze the qualitative data, then integrate the qualitative results to explain the quantitative findings. Such designs are common, and well regarded, in counselling psychology (Hanson et al., 2005; Jacobson et al., 2015; Merker et al., 2010) and are actively called for in suicidology (Kral et al., 2012).

In the present study, integration happens three times. Firstly, the survey results were used to develop the interview protocol and follow-up research questions. Secondly, the survey results were used to purposefully select a sample of follow-up interview participants with the intention of demographically representing both the survey sample and psychologists in Canada. Lastly, the quantitative survey and qualitative interview results were combined as integrated findings, providing a cogent narrative answer to each research question.

Significance of the Study

This study: (a) adds clarity to an important public health issue and (b) can inform future SRA training to better address this important issue.

Suicide is devastating. Nearly 2,000 people die by suicide globally every day, meaning there are more deaths by suicide than there are due to homicide, breast cancer, war, or Malaria (World Health Organization, 2021). It is disproportionately represented in adolescents and young adults, low- and middle-income countries, and those who have already lost someone to suicide. For each death, an estimated 135 are exposed, affected, or bereaved (Cerel et al., 2019), all of whom are at higher risk of developing complicated grief (Shear et al., 2011; Tal Young et al., 2012). Not many are saved from this exposure, as 85% of people in the United States are estimated to have personally known someone who has died by suicide in their lifetime (American Foundation for Suicide Prevention, 2007). The prevalence

of suicide-related distress rises steeply when considering that for each death by suicide 25 attempt to die by suicide and 75 seriously consider an attempt (Nock et al., 2008). Indeed, the lifetime prevalence of suicidal ideation is 10.6%, which is a deleterious and psychologically painful process (Liu et al., 2020). And although suicide rates have remained stable for decades, recent public health challenges such as the opioid crisis (Oquendo & Volkow, 2018), COVID-19 (Curtin & Ahmad, 2022), and the sociological and economic impacts from climate change (Belova et al., 2022) have already significantly increased, and are predicted to continue increasing, the incidence of suicide and suicide-related behaviour. The focus of the present study is a significant public health problem that is presumed to worsen; scholarship around mitigating the harms and consequences of suicide is meaningful and worth studying.

The results of this study are also uniquely positioned to inform and improve SRA training. By conducting a MMR study, we can describe psychologists' SRA practices, trainings, and experiences with the survey, and explain their origins and development through the follow-up interviews. With these integrated results, we can identify gaps in graduate SRA training, understand what kind of training might best fills these gaps, and develop training that is cognizant and targets of psychologists' negative, or positive SRA experiences. Perhaps most importantly, improved SRA training for psychologists will have downstream effects on both clinician well-being and client care.

As reviewed, SRA is one of the most stressful experiences for clinicians, and our ethico-legal predictive frameworks appear to be the root of this stress (Dubue & Hanson, 2020). By teaching updated SRA models, which are prevention- and collaboration-focused, clinicians are likely to experience less fear when conducting SRAs, reduce their stress, and find more capacity for focusing on their client's therapy goals (Truscott, 2021). Clients stand to benefit from their clinicians having updated SRA training, in that prediction-focused SRA practices can be autonomy-restricting, neglectful of the client's goals, and relationally harmful, whereas more prevention-focused SRA practices focus on collaboration and treating the driver of the client's suicidality (Hawton et al., 2022). Not only do the latter show better

effectiveness data in reducing SITBs, but they are also better tolerated and often welcomed by clients (Ferguson et al., 2022). The present study helps bridge a major gap between what clinical research shows as effective and what is routine clinical practice; using these results to rationalize and identify better SRA training will better clinician well-being and suicidal client care.

Relevance to Counselling Psychology

This study is relevant to Counselling Psychology (CP) in three ways: (a) it upholds CP's value of social justice, (b) it intersects harmoniously with CP's three roles, and (c) it offers CP an opportunity to lead practical social and psychological change.

Social justice has been foundational to CP (Gelso et al., 2014). This is enacted by CP programs teaching multicultural counselling, educating students on systems of oppression, and viewing mental health as entrenched within broader contexts of inequality and marginalization (Kozan & Blustein, 2018). However, CP has been criticized for espousing the values of social justice, while avoiding directly addressing and advocating for social change (DeBlaere et al., 2019). Notably, at the 2018 Canadian Counselling Psychology Conference in Calgary, of which the theme was "Advocating for ourselves, advocating for our communities", a significant focus aimed to bring social justice "to the forefront of multiple critical conversations" (Counselling Psychology Section, 2019). SRA is one such critical conversation (Button, 2016). In Canada, some communities are disproportionally affected by suicide, including First Nations, Métis, and Inuit communities (Kumar & Nahwegahbow, 2016; Persad, 2017), LGBTQ2S+* (Marshall et al., 2016), newcomers (Byrow et al., 2020; Meyerhoff et al., 2018), People of Colour (Sutter & Perrin, 2016), those with poor access to education (Case & Deaton, 2015), and who have high levels of economic or housing uncertainty (Public Health Agency of Canada, 2018). Autonomy-restrictive practices, such as hospitalization and NSCs, risk doing more harm to communities who historically and systematically have had their autonomy and liberties legally threatened and sometimes removed. Given how graduate training in counselling psychology focuses on activism, teaches

sociological theories, and is often in direct contact with those experiencing suicidal ideation, we are exceptionally well positioned to advocate for better suicide prevention at the individual, community, and sociological level (DeBlaere et al., 2019).

The three main roles of counselling psychologists, intervention, prevention, and education, intersect with SRA best practices. SRA requires an act of intervention, where the psychologist is actively working with their client to better understand their suicidality, create a self-safety plan, and treat the drivers of their pain (Jobes, 2016). SRAs are also preventative, as understanding their drivers to suicide, continued monitoring, and check-ups aims to avoid increased psychological pain for their client (Silverman & Berman, 2014a). Lastly, contemporary models of SRA intend to make the client experiencing suicidal ideation their own suicidologist, such that they are aware of what factors perpetuate psychological pain, increase their risk of death, and how they are capable of treating themselves (Jobes & Chalker, 2019). As it stands, SRA requires a balance of all three roles for best practice, and counselling psychologists are already well trained in managing the conflicts and benefits of these intersecting roles.

Lastly, given the field of SRA is interdisciplinary, no one profession has claimed best practice, training, research, or leadership in the area. Although decentralization is helpful in involving many professions, it also holds an opportunity for CP to directly involve itself in treating, preventing, and educating health professionals on SRA. The benefits of this would be widespread, with the first being that psychologists could promote themselves as being the main point of contact when experiencing high suicidal ideation. At the moment, lay audience publications, such as Dastagir's (2020) article in *USA Today,* highlight that most mental health professionals are not trained enough in comprehensive SRA, despite recent evidence that internship-ready psychology graduate students are competent (Kerr, 2019). Secondly, SRA research and practice continues to see suicide treatment through an individual lens, whereas we know the solutions to be systemic, intersectional, and rooted in social justice. If CP stakes a

presence in the field of suicide and SRA, we may decrease problematic hospital admissions, which increase psychological distress (Hagen et al., 2017), and further advocate for community and social change to prevent suicide. Lastly, SRA is a large field, with considerable opportunity in municipal, provincial, and federal leadership on health policy boards. Given Sinacore (2018) called for CP to be seated at "bigger tables", expertise in suicidology could meet this demand and leap frog into additional high-level advocacy and policy positions.

Chapter II: Review of the Literature

In this section, I review literature that details how psychologists practice, learn, and experience SRA. Specifically, I have divided this review into four sections: (a) psychologists' SRA practices, (b) psychologists' SRA training, (c) psychologists' SRA experiences, and (d) gaps in the literature.

Despite suicide research sextupling in volume over the last 30 years (Astraud et al., 2020), psychologist-specific research is still limited. Therefore, I have included some relevant research that recruited other mental health clinicians in their sample.

Psychologists' SRA Practices

In this section, I review eight studies that ask the question: what are clinician's SRA practices? Five of these studies included psychologists in their sample, whereas three included other mental health professionals.

The study that first reviewed psychologists' SRA practices is Bruno's (1995) dissertation. Bruno's (1995) main research question was "What are the experiences of the average psychologist when working with suicidal outpatients?", which included a brief examination of psychologists' SRA behaviours and training. The author randomly sampled 475 psychologists from the American Psychological Association's mailing directory and was returned 319 surveys (67% response rate). Psychologists rated the frequency of their SRA behaviours on a 7-point Likert scale ranging from 1 (never) to 7 (always). The most frequently endorsed behaviours, rated between 6.2 and 6.8, included determining the presence of a support system, assessing if their patient can manage recurring suicidal feelings, assessing clients' marital/family relationships, assessing the strength of the therapeutic alliance, and evaluating hopelessness/helplessness. Less endorsed behaviours, rated between 5.0 – 5.9, included increasing the amount of written documentation in their chart, evaluating the appropriateness of a no-suicide contract, referring to psychiatry, consulting with peers, having patient sign a consent form, and increasing the number of treatment sessions. The least endorsed behaviours, ranging from 4.0

to 4.9, included performing a formal risk assessment every session, creating/charting a diagnosis, and performing a mental status exam, with the lowest endorsed behaviour as giving their patient their home phone number, rated on average at 3.4. Bruno (1995) also examined psychologists' experiences of working with suicidal clients. They found 91% of psychologists typically see at least one client where suicide is a concern per month, and that that an average of 5 clients have attempted suicide and 0.4 clients have died by suicide while in the psychologists' care. Most respondents believed that suicide attempts and deaths by suicide were "totally unforeseeable" or "almost always unforeseeable", and that, when a death by suicide does occur, 81% would "frequently" connect with the survivors and 47% would "frequently" contact their lawyer immediately. A majority (47%) of psychologists indicated that managed care has "frequently" decreased their effectiveness of SRA. Most psychologists (43%) feel occasionally overwhelmed by a difficult suicidal client, 44% would infrequently consider a transfer, and 74% would frequently seek consultation. Ultimately, Bruno (1995) rightly concluded that these were the first baseline data collected on psychologists' SRA practices, and one of the first on their experiences, as the remainder of the studies reviewed in this section aggregate psychologists with other mental health professions.

While Bruno (1995) focused specifically on psychologists, and consequently collected a sample of predominantly private practice clinicians, a large majority of SRA practice literature focuses on the experience of clinicians in medical settings (Steeg et al., 2018). Targeting hospitals and community clinics, Rothes and Henriques (2018) used snowball sampling to recruit 239 psychiatrists, general practitioners, and psychologists in Portugal to answer questions on their SRA practices. Their author-developed survey was based on their previous qualitative study examining suicide management practices in the same population. Here, the authors separately analyzed their results for each profession in their sample; as such, I will primarily review the results for the psychologists. The 126 (52.7%) psychologists from the sample largely endorsed conducting SRAs (88.1%) of some type, although few

were formally trained (18%). Most psychologists asked about lethal means (68.3%), tried to understand the motives that triggered an attempt (93.7%) or its meaning (96.8%), ask about reasons for living/dying (61.1%), about hopelessness (68.3%), and drugs or alcohol (69.0%). Among other risk assessment questions, 38.9% endorsed using published instruments, the highest compared to psychiatrists and general practitioners, and are also more likely to refer to psychotherapy as treatment (85.7%) in their treatment plan. To prevent suicide, 35.7% of psychologists set written suicide prevention contracts, 40.5% give their mobile phone number, and 61.1% carry out personality evaluations. In referring to other services, psychologists were the least likely to recommend hospitalization (14.3%), 49.2% refer to a colleague who is better prepared in this area, 83.2% refer to psychological counselling, and 69.8% refer to a medication-prescribing professional. Regarding the clients' family, most psychologists engage the family in this prevention process (86.5%), 38.9% conduct a family interview, and 38.9% provide counselling to the family. Rothes and Henriques (2018) also found that more SRA training and having a higher number of patient suicide attempts led to a higher endorsement of suicide prevention behaviours, such as using formalized assessment tools and involving family members. They imply their results support the need for more SRA training for professionals, given it appears effective, and that this training should include safety plans, focus on connectedness, and be taught experientially.

Berman and colleagues (2015) approached the exploration of SRA practices in psychologists differently, specifically by having psychologists (79.7% of sample) read two suicide-related vignettes and then rating their perceived likelihood of suicide and need for hospitalization. The participants, nearly half of which practiced within hospitals or university clinics, had high heterogeneity in estimating suicide risk and endorsing hospitalization. They found the only risk factor that predicted suicide estimates was the patient's access to psychotropic medicine, and those who were licensed endorsed hospitalization more than trainees. Other practice characteristics, such as hospitalization history, clinician comfort with suicidal clients, or knowledge of suicide-related facts, did not meaningfully predict clinician's estimates

of risk. Interestingly, demographics such as clinician's relationship status and religiosity were significantly predictive; those who were single or highly religious were more likely to endorse higher suicide risk and hospitalization. As well, women were more likely to endorse high suicidality in the male client vignette, and males were more likely to endorse high suicidality in the female client vignette. The authors explain these results, suggesting that groups with a tendency to risk-aversion (e.g., religious, women, and single) are more likely to take precautions. They conclude that their data is evidence that clinicians are not homogenous assessors of suicide risk, and that clinician demographics and practice characteristics invariably affect their clinical judgement.

Roush and colleagues (2018) also examined SRA and management practice frequencies and their association between fear of suicide-related outcomes (e.g., client death) and the adequacy of SRA management decisions (e.g., deciding on hospitalization). The authors surveyed 289 mental health professionals, most of whom were women (75.8%) social workers (25.3%) from the United States (91.0%). Only 23.5% of the sample were psychologists and, as a result, these data should be compared cautiously to the present study's findings. Most participants (68.9%) routinely asked about current, recent, or remote suicidal thoughts or behaviours on first visits. When they learn a new patient is actively thinking about suicide, participants predominately conduct an SRA and change their treatment plan accordingly (77.2%), develop a collaborative safety plan (67.8%), and provide a crisis line number (63.7%). Less than the majority continue to see the patient (44.3%), conduct a means-restricting counselling session (33.9%), immediately refer the patient to a hospital emergency room (7.6%) or inpatient psychiatric unit (3.8%), and get a signed no-suicide contract (22.1%). They also reported that, on a scale of 1 (not at all) to 5 (completely), they fear a patient suicide the most out of all possible clinical situations (3.49), more than being sued for malpractice (2.82) or a patient physically assaulting them (2.30). The authors conclude that there is significant inconsistency in SRA practices across practitioners, however, fear was not related to a clinician's ability to implement evidence-based suicide

prevention measures. Indeed, most practitioners were comfortable (rated a 4.1 on a 5-point scale where 4 represented *comfortable*) working with suicidal clients, more so than working with those with substance-related disorders, eating disorders, and sexual and gender identity disorders. Ultimately, they are consistent with other authors cited in this section in stating that there is a continued need for more evidence-based SRA training, given the high prevalence of non-evidenced SRA practices (e.g., no-suicide contracts).

Rozek and colleagues (2022) recently studied how 613 mental health clinicians and 158 mental health allies (e.g., teachers, first responders) conducted SRA and management. Of the 613 clinicians, a majority were psychologists (Rozek, personal communication, October 21, 2022). Here, the authors asked participants to indicate all SRA and management practices through a checklist: "When a client presents with suicidal ideation and/or behaviors do you use any of the following (check all that apply)." Most mental health clinicians endorsed using a safety plan (84.4%) or a crisis response plan (47.6%) and endorsed using hospitalization for suicide prevention (70.1%), while a minority endorsed using contracts for safety (35.6%), no harm contracts (15.0%), or no-suicide contracts (13.7%). The authors here argue that further clinical education on best SRA and management practices is insufficient, and that there should also be a movement to "de-implement" contraindicated strategies such as suicide-related contracts.

Although there are only a few studies examining psychologists' SRA practices, there exists at least three other studies that asked similar research questions and used similar designs, but examined a different population. Higgins and colleagues (2016) had 381 mental health nurses in Ireland complete a survey which examined their practices and confidence in SRA and safety planning. Specifically, they listed 28 SRA behaviours and asked participants to endorse if these were never, rarely, frequently, or always used. They reported most (95.7%) of participants conducted SRAs, often prioritizing risk factors related to the self (e.g., history of suicide attempts, history of self-harm), and risk factors related to

others (e.g., violence/aggression history, anti-social behaviour). Regarding safety planning, participants primarily endorsed autonomy-supportive measures, such as frequently asking the client what they need to do to keep safe (65.6%), identifying harm minimization strategies (60.4%), and giving risk reduction advice (57.5%). They conclude, similarly to other cited studies that, clinicians stand to benefit significantly from training in holistic SRA conceptualization and collaborative safety planning.

Love and colleagues (2020) studied the SRA practices of marriage and family therapists, only 40% of whom are presumed to have been exposed to SRA training (Bongar & Harmatz, 1991). Here, they asked 39 marriage and family therapists a broad open-ended question with a short preamble: "You have an individual client in session that expresses an intense wish to die and means to do so. Please explain the steps you would take in the session and following the session to reduce this client's risk of dying." Afterwards, they had participants read three vignettes and were then asked to rate the client's risk of dying. From the open-ended question, participants predominantly assessed for the client's suicide plan, discussed the implementation of hospitalization (38.5%), or considered involving familiar supports (25.6%), among numerous other, less frequent, answers. From the vignettes, participants again predominantly assessed for the frequency and severity of suicidal thinking and followed-up by asking about their plan, endeavoring to use this information to create a safety plan and identify the need for hospitalization. The authors conclude that, there is, like others, inconsistency in how marriage and family therapists conduct SRA and manage risk, with numerous contraindicated practices endorsed. They recommend standardized and updated training for clinicians, specifically through continuing education credits.

As reviewed in this section, psychologists are exposed to suicidal clients often and, when they are, they almost always conduct an SRA. These SRAs are often information-gathering focused, with an emphasis on identifying risk factors, lethal means, and safety planning. An estimated third of psychologists utilize standardized SRAs to ask these questions, whereas the remainder appear to weave

these questions into an idiosyncratic structure. Although rates have decreased over the years, an estimated third of clinicians still use no-suicide contracts which has been contraindicated for decades, and anywhere from 14-70% consider hospitalization when working with a suicidal client. From these findings, most authors conclude that SRA practices of clinicians are understudied and inconsistent, with a majority recommending better and more consistent SRA training.

Psychologists' SRA Training

Indeed, what and how do psychologists learn about SRA? I divided this section into two parts: studies examining (a) graduate programs trainers' and trainees' SRA training experiences and (b) graduated clinicians' reflections on their SRA training.

Graduate Programs Trainers' and Trainees' Experiences

Bongar and Harmatz (1991) were among the first authors to examine the question: how are psychologists trained in SRA? They approached this question from the top-down, surveying 25 (76% of total) faculty members of the National Council of Schools of Professional Psychology (NCSPP) and 92 (80% of total) faculty members of the Council of University Directors of Clinical Psychology Programs (CUDCP), both institutions that regulate and guide the development and maintenance of graduate professional psychology training programs. They found that, on average, only 39.3% of graduate training programs in professional or clinical psychology offered formal training in the study of suicide. Most of the training came in the form of lectures (22.8-26.9%) and seminars (12.0-19.2%), often incorporated within other courses (82.6-92.0%). A majority of the teaching faculty have treated or assessed suicidal patients (79.0-86.8%), although few were highly experienced (35.2-47.2%), and around half believed faculty did not need direct clinical training to formally teach SRA (36.0-52.2%). A minority believed that SRA and management training should come from graduate coursework (22.8-46.0%), practicum (19.0-43.5%) or internships (15.0-37.0%). The authors note that these findings indicate that graduate programs are not sufficiently preparing psychologists for SRA practice, and do not feel wholly

responsible to do so, either. However, they also discuss how professional psychology, at the time, had just recently moved from a minor to a major player in healthcare disciplines, and that a growing list of psychologists were encountering suicidal clients in hospital milieus. Although they do conclude that SRA training was insufficient, they clarify this was a problem across all health fields at that time; psychology was just no exception.

Dexter-Mazza and Freeman (2003) continued this line of inquiry but came at it from the bottom-up. They randomly surveyed 238 pre-doctoral psychology interns from the Association of Psychology Postdoctoral and Internship Centers' (APPIC) membership (40% response rate) and assessed the frequency of their SRA practice and their training. Most participants were working towards a Ph.D. (70.3%) in clinical psychology (76.1%) and were attending an APA-accredited program (95.8%). Nearly all (99.2%) participating psychology interns reported treating at least one suicidal client during their training, 4.6% of which had lost a client to suicide. A near even division said their training program offered formal SRA training (50.8%), the most frequently endorsed method being via lecture (73.8%) followed by internal practicum (41.3%), external practicum (32.2%), and colloquium (32.5%). Most of the training was teaching assessment (99.1%) and crisis response (83.6%), while just above half were taught prevention (57.4%) and a third postvention (32.0%). Seventy-five percent endorsed receiving this training spread between two and five courses, and most (60.1%) believed they should get their SRA training from practica whereas only 33.0% thought it should come from formal coursework, similar to the opinions of faculty in Bongar and Harmatz's (1991) study. Trainees largely believed they were able to accurately assess suicide risk (*M* = 5.3 on a 7-point scale), could manage a suicidal client (*M* = 4.9 on a 7-point scale), and are knowledgeable regarding suicide and working with suicidal clients (*M* = 4.9 on a 7-point scale). Interestingly, despite some trainees not receiving any SRA training, their confidence in working with a suicidal client was the same as those who had received training. The authors conclude that, despite evidence that trainees are getting more SRA training compared to a decade ago, there

remained a near 50% chance that suicidal clients were working with trainees who had not received formal training. Given that suicidal clients are one of the most-high risk populations psychologists treat, the authors recommended that graduate training programs adhere to the scientist-practitioner or practitioner-science model and increase opportunities for formal SRA training, including more formal coursework.

Narrowing the scope to just one APA-accredited clinical psychology program in the United States, Mackelprang and colleagues (2014) surveyed 59 doctoral trainees on their SRA training and related these findings to a self-reported SRA competency measure. Most participants were white (66.1%) women (91.5%) completing their second year of clinical practicum (33.9%). Most trainees received in-class training on SRA or intervention (76.3%) followed by personal reading (47.5%), continuing education (37.3%), socialization with peers (35.6%), or employment outside of graduate training (23.7%). Here, participants mostly learned about risk assessment (64.4%), legal and/or ethical issues (54.2%), suicide prevention (52.5%), no-suicide contracts (49.2%), documentation (42.4%), and postvention (22.0%). Most agreed or strongly agreed that they were knowledgeable about risk factors and legal/ethical factors, whereas about half felt confident to assess for suicide effectively and document that risk. They also found that students with more clinical training and exposure to suicidal clients endorsed more correct answers on their competency measure, suggesting that trainees get better at SRA with experience. However, they note the amount of formal SRA training did not have an impact on competency, which the authors hypothesize is because training is inadequate, focusing too much on didactics and not enough on "real-world" experience. The authors discuss how there continues to be an increase in training programs having SRA as a competency; they report 80% of trainees received formal SRA training, which is significantly higher than the 50% reported in Dexter-Mazza and Freeman (2003) and 39% in Bongar and Harmatz (1991). However, despite this increase, the authors conclude that programs have not yet implemented core competency training (Cramer et al., 2013), meaning that

the SRA training received continues to be idiosyncratic and overly didactic, rather than standardized and experiential.

Given much has changed since Bongar and Harmatz's (1991) study, Liebling-Boccio and Jennings (2013) aimed to update our understanding of how professional psychology program directors teach SRA. They surveyed 75 directors and coordinators of graduate programs in school psychology that were approved by the National Association of School Psychologists (NASP) about how they train their students in SRA. Most participants (97.6%) indicated their program covered SRA training through lecture and discussion, and 78.8% further commented that this training is also covered during internship, externship, or practica. However, participants noted that the length of time spent covering said topics is rather minimal; 18.8% said they spent less than 2 hours on SRA training, 29.4% said 3-4 hours, and 51.8% said 5-6 hours, with no notable differences found between doctoral and nondoctoral programs. Most training was didactic and in class (94.1%) or class assignments (89.4%), with around half (54.1%) receiving in-class role-plays, on-site training (48.2%), or off-site training (43.5%). The content often taught was interpersonal skills (96.5%), translating information into recommendations (91.8%) and conveying said recommendations (89.4%), whereas the least taught was quantitative rating scales (54.1%) and standard or structured protocols (63.5%). From this SRA training, most directors believed their students were somewhat to mostly prepared to assume the professional responsibilities associated with SRA, prevention, intervention, and postvention. They believed students were least prepared to facilitate hospitalization, use quantitative measures, and conduct school-wide screening and prevention programs, while most prepared to address the limits to confidentiality, identify risk/warning factors, and use interpersonal skills. Most directors also agree or strongly agree that suicide is a serious problem (98.8%), that training in SRA is extremely important (98.8%), and that it is the responsibility of a graduate institution to instruct students in SRA (91.8%). The authors note this is a significant shift in how training directors see their role in preparing psychologists to conduct SRA, compared to the 23-46% of

faculty members in Bongar and Harmatz's (1991) study who believed SRA should be taught as graduate coursework. Although graduate programs are more likely to offer SRA training, they remain unaware that their training may be insufficient. The authors note that most clinicians only get 5-6 hours of SRA training, that the training continues to rely on lecture-based didactics, and they are unaware if what is being taught is up to date. They recommend, as others do, that SRA training should be more experiential (e.g., role-plays), focus on supervisors in externship, internship, or practica, and teach from a standardized curriculum.

In reviewing this SRA training literature, Monahan and Karver (2021) noticed significant gaps. They discussed how studies are outdated (Bongar & Harmatz, 1991), combines multiple different psychology programs (Dexter-Mazza & Freeman, 2003), focus directors of clinical training programs (Liebling-Boccio & Jennings, 2013), or only examines one program (Mackelprang et al., 2014). The authors note that, what is missing, is a broad and systematic review of how psychologists are trained in SRA. To partly fill this gap, the authors surveyed 267 clinical psychology trainees from at least 48 different universities and asked them about their SRA competency and related the results to the theory of planned behaviour. Using path analysis, the authors aimed to understand how psychology trainees came to learn and practice SRA by examining their attitudes towards SRA, perception of how their peers value SRA, and belief that they can conduct SRA. Importantly, they asked participants to only discuss their graduate-level SRA training and to withhold their extracurricular experiences. They found that nearly all participants (96.4%) received some form of SRA training, with an average of 10.74 hours that was received through part of (68.3%) or an entire lecture (59.9%). As well, most participants received SRA training through external practica (64.7%) and were prepared through having completed some role-play practice (70%). Comparing SRA competency to the theory of planned behaviour factors, the authors found that participants' attitudes towards SRA and belief they can conduct SRAs are significantly correlated to intentions to conduct SRAs, whereas the belief that peers find SRA important had no

significant correlation. In a separate model, the authors also found that the amount of training received was not significantly correlated with attitudes, belief they can conduct SRA, or the belief that peers find SRA important. The authors interpret these findings by suggesting SRA training content is sufficient, but the method is not. They argue SRA training programs could be improved if they target improving trainee's SRA attitudes and perceptions that they are capable in conducting SRA, specifically through an experiential approach (e.g., role-plays, modeling, in-vivo feedback). Indeed, only half of training programs reviewed by these authors emphasized experiential training, which is consistent, if not a touch higher compared to other studies. They conclude by acknowledging the significant growths in time spent teaching SRA and management, but note experiential pedagogy is best for the limited time spent teaching the stressful and difficult practice of SRA.

Monahan and Karver (2021) also noted that SRA training was significantly lacking in pedagogical rigor, and that students were receiving disparate SRA training experiences. To better understand how clinicians were being taught SRA, Binkley and Elliott (2021) used a quantitative content analysis to analyze how well SRA training aligned with organizational standards and theoretical frameworks. Here, they reviewed 26 articles published between 1993 and 2018 which were predominantly in the field of counselling (38.5%), psychiatry (19.2%), general mental health (19.2%), and psychology (15.4%). They discussed three primary findings: (a) best pedagogical practices, (b) alignment with standards of practice, and (c) alignment with theory and pedagogy. In terms of instructional methods, most SRA training literature recommended SRA be didactic (e.g., lectures) or experiential (e.g., role-plays), followed by demonstrations/vignettes, discussion, and supervision, often spread out across courses. They also identified that most SRA training literature recommended trainers assess their student's self-efficacy/attitudes and knowledge/competency. However, although most made these recommendations, few included them in their research questions and even fewer studied their presence directly. Nine of the 26 articles directly related to their teaching content to institutional standards and only 6 referenced

pedagogical frameworks from which they taught SRA. Said differently, the authors note how SRA training is based almost exclusively on the idiosyncratic interpretations of the trainer, with little evidence that they have reviewed recent literature, are expertly trained in SRA, or are following best teaching practices for a difficult skill like SRA. The authors of this broad review conclude the SRA literature has a strong grasp of what information needs to be taught but is deficient in understanding how clinicians learn, or should learn, SRA. They highlight that very few clinicians are trained based on institutional standards, few trainers report the pedagogy used to teach SRA, and few studies understand how clinicians get better at SRA. They highlight that future SRA literature should include measures of SRA competence and better identify the process of how clinicians feel confident and prepared to conduct SRA.

In his dissertation study, Kerr (2019) addresses part of this content gap, specifically by examining health psychology graduate students' experience, training, and competency in SRA. Kerr recruited 104 internship-eligible health service psychology students in doctoral programs exceeding two years, which were mostly female (82.1%), European American/White (80.7%), in the third (27.1%) or fourth (32.9%) year of their clinical (52.9%) or counselling (33.6%) program. He asked them to complete previously published measures such as the Suicide Intervention Response Inventory (SIRI), Attitudes Towards Suicide Scale (ATTS), and Suicide Competency Assessment Form (SCAF), all of which address some of the pitfalls identified in Binkley and Elliott's (2021) content review. Kerr further surveyed participants on their own mental health experiences, where most reported previous or current mental health treatment (80.0%), 49.3% reported a previous or current mental health diagnosis, and 22.9% reported a prior history of suicidal ideation and/or attempts. On average, participants rated themselves as competent in SRA, with most reporting previous exposure to a client with suicidal ideation or attempt (95.7%) and having been instructed in SRA in their doctoral program (77.9%) or trained in suicide intervention externally (58.6%). Most students disagreed with common suicide myths (83.6% - 97.1%) and scored in

the "advanced graduate student" range on a measure of SRA skill and knowledge, although a majority (65.7%) indicated a desire for further training. Kerr found students' self-rating in SRA competency correlates significantly with their SRA skill, and those with previous clinical experience with suicidal clients were more comfortable in discussing suicide with clients and peers. Further, some null correlations highlighted interesting conclusions, such as personal qualities not correlating with competence, and attitudes not correlating with SRA knowledge or competence. These results offer insight into some previous findings. Firstly, Monahan and Karver (2021) found that SRA attitudes were correlated with SRA intention, whereas Kerr (2019) found attitudes had no effect on competency. Despite these competing findings, there remains a strong rationale for assessing and intervening on SRA attitudes in trainees, given attitudes are likely predictive of fear and confidence in SRA (Cwik et al., 2017; Diekstra & Kerkhof, 1988). Further, Kerr found doctoral psychology trainees were competent in SRA, which was consistent with calls to base SRA training on core competencies (Cramer et al., 2013), potentially suggesting idiosyncratic SRA training is sufficient in teaching competent SRA practice. However, Kerr notes that most students were also trained externally and that a fifth did not receive any training, supporting his call that the APA include SRA and management as a core competency in accreditation standards, that federal and state boards should include SRA-related test questions, and SRA should be a regular part of continuing education.

Combined, these studies provide a glimpse into the evolution of graduate-level SRA training. Its prevalence has increased throughout the last three decades, suggesting that most psychology trainees have some exposure to SRA training. It is primarily taught in a didactic lecture format, often spanning multiple courses, with some trainees also practicing their skills through role-plays and vignettes. Although many researchers recommend, with compelling evidence, that SRA be taught experientially, very few trainers report on the pedagogy used to teach SRA to their students. Further, we have limited research on if this training is effective at increasing SRA competence, as most studies do not include

such measures. However, it remains clear that SRA training is considered important by trainees and faculty and increasingly being addressed in graduate training.

Graduated Clinicians' Experiences

The studies previously reviewed examined trainees and trainers' SRA training experiences, which provides perspective on what and how SRA is being taught. In this subsection, I review studies that ask practicing clinicians how their SRA training informed their current SRA practice.

Erps and colleagues (2020) is one such study and is one of the few to exclusively study psychologists' SRA training and experiences. Here, they used snowball sampling to survey 92 practicing school psychologists in the United States on their perception of their role in SRA, including competency, comfort, and confidence in intervening. The survey included items the authors modified from a similar study on secondary education teachers (Hatton et al., 2017), original items identifying roles for school psychologists when conducting SRAs, demographics, and open-ended questions on the use of universal screening. The authors elicited and incorporated feedback on their survey from other psychologists and educators in school psychology prior to data collection. Erps and colleagues found that less than half (45.7%) had received graduate level training in SRA, whereas the remainder of the sample did not receive training or did not remember. Most of the sample (58.7%) was not exposed to SRAs during practicums, instead, primarily received their education through internship (64.1%) and post-graduation professional development (78.3%). Nearly all participants believe school psychologists have a role in SRA (90%), although less (70%) conduct them. The primary role of school psychologists conducting SRA is in direct one-on-one intervention with a youth experiencing suicidal ideation (67.4%) and postvention with staff and students (53.3%). Most participants believe they know suicide risk factors and warning signs (94.6%) and feel confident handling a crisis (76.1%), but also endorse their graduate training in SRA as insufficient (63.0%). Lastly, nearly half of participants believe suicide should be universally screened in schools (48.1%), largely through classroom discussion and presentation. Overall, the authors report that

school psychologists believe they are poorly trained in SRA and have varying levels of perceived competency, all of which they believe is because of inconsistent and insufficient graduate-level training.

Further studying school psychologists, O'Neill and colleagues (2019) examined their training, experiences, and access to school district protocols in suicide postvention. The authors recruited 111 school psychologists in North Carolina, United States through relevant listservs, accounting for nearly 20% of all practicing school psychologists in the state. The authors developed the 31-item Perceived Postvention Competency Survey, which assesses school psychologists' experiences with postvention response, graduate training and post graduate training opportunities, and the availability of district resources. The scale was reviewed by school psychologist peers, educators in the field, and was pilot tested on 10 school psychologists. Most participants (68.4%) identified having some postvention training, although fewer had experience providing the service (40.5%). Participants claimed they were slightly knowledgeable (49.5%) or moderately knowledgeable (36.9%) in suicide postvention, with most reporting they are less than moderately prepared to provide such a service (61.0%). Participants endorsed higher confidence in their postvention skills when they had formal training, had more work experience, and were working with older students. Overall, this study shows most school psychologists in North Carolina believe they have limited competency and experience in suicide postvention, which they believe should have been rectified by better SRA and management training.

Given suicide is more prevalent in rural than urban areas, particularly in youth (Hirsch, 2006), Brown and colleagues (2017) surveyed school psychologists in Montana to understand their SRA training and involvement. They recruited 37 practicing school psychologists through the Montana Association of School Psychologists' membership listerv and by email, most of whom were female (86%), white/non-hispanic (97%), and had been practicing for more than 10 years (46%). Most psychologists had zero courses exclusively devoted to SRA (91%), but had at least one course with partial content devotion (80%). Most psychologists had more than 10 hours of post-graduate SRA training (58%) whereas 39%

had less than 5 hours, which is predominantly conducted at non-conference workshops (76%) and conferences (61%). Participants also commented on the barriers and challenges of SRA and training, identifying nine main themes. 31% of psychologists felt frustrated about the lack of community health support and follow up, 24% identified that they had too many obligations which impeded their SRA practice, and 22% commented that they did not know of standard school suicide prevention procedures. This feeling of being overworked and isolated was consistent with the comments of 16% of the psychologists who discussed their lack of SRA resources and training, and another 16% who also noted a lack of team collaboration. Experience-wise, psychologists felt limited in conducting SRA and prevention efforts because they felt their relationships with students was limited (8%), that parents/school professionals didn't understand suicide or take it seriously (16%), that there was a lot of suicide-related stigma (14%), and that rural areas typically had better access to lethal means (8%). In addition to rural-specific challenges, the authors note that psychologists are likely to benefit by receiving more consistent and complete SRA training, as participants identified their main challenges (e.g., not knowing standard practices, lack of training, suicide-stigma) could be abetted by better training. However, they also note that the responsibility of SRA training is not individual, but program-level; they recommend SRA training be more prevalent in graduate-level training, rather than post-graduate, especially given that most rural psychologists often practice in isolation from peers and have more limited continuing education opportunities.

Gerardi (2018) more broadly examined mental health practitioners' SRA and management practices, particularly with children and adolescents. In their dissertation study, they recruited 357 mental health professionals, including school psychologists (21.4%), clinical/counselling psychologists (15.9%), mental health counselors (14.8%), and social workers (14.0%), to complete a survey on their SRA training and experiences. Nearly all (91%) participants reported some SRA training, although only half (53.3%) reported taking a didactic graduate-level course, a finding that was consistent across degree

levels (e.g., Master's-level vs doctoral-level), profession, and status of licensure. Said differently, the author noted that SRA training is typically provided at the beginning of a professional's development and very rarely expanded upon with further education unless it is individually sought. Participants reported their most endorsed SRA training was self-guided journal readings (91%) and only a third of participants reported taking SRA-related continuing education courses, 17% of whom further identified that they did it because it was required by their professional association. Participants were moderately confident in their ability to effectively treat suicide (average 4.7 on a 7-point scale) and rated themselves moderately knowledgeable about suicide (average 5.2 on a 7 point-scale). Interestingly, and counter to most evidence on the subject, participants in this study were significantly more judgemental of those with suicidal ideation compared to a normative population of college/university students. Participants here endorsed that those who die by suicide are "punishing others", "selfish", or "weak". Also importantly, the more training and exposure participants had to SRA, the less they endorsed stigmatizing statements. Participants were also asked to review suicide-related vignettes and answer questions regarding their responses. For the low- and medium-risk vignettes, only 1% of participants recommended hospitalization, and in the high-risk vignette, 7% recommended hospitalization and over a third recommended emergency services. Gerardi (2018), having reviewed a wealth of SRA practices, training, and experiences in mental health professionals, summarized their study by suggesting that more and better training in SRA and management is warranted. They hypothesize this would increase clinician confidence and the likelihood of using effective interventions while decreasing suicide-related stigma.

Effective intervention is typically culturally sensitive too, yet is an often neglected feature in contemporary SRA (Lopez-Castroman et al., 2015; Sommers-Flanagan & Shaw, 2017). Examining culturally competent SRA (CCSRA), Chu and colleagues (2017) assessed doctoral-level psychologists' knowledge, comfort, frequency of, and barriers to CCSRA. CCSRA is broadly defined by the practitioners'

inclusion of a culturally minded assessment of their client's views of suicide, its cultural acceptability, and relevant religious spiritual components (Chu et al., 2018). Chu and colleagues randomly selected psychologists from APA's Division 12 (Clinical Psychology) and 42 (Independent Practice) online directories, of which 161 fully participated in the study. The authors developed the original survey items, although items on Barriers to CCSRA were generated from a brief qualitative inquiry with 38 expert stakeholder psychologists, and analyzed using thematic analysis (Braun & Clarke, 2006). Overall, psychologists reported an adequate to good amount of SRA training (*M* = 2.44 on a 4 point scale) and CC training (*M* = 2.16), but barely any CCSRA training (*M* = 1.09). Most SRA training was postgraduate on-the-job (79.4%), post-graduate workshops (78.8%), or as needed (50.0%). Psychologists were comfortable practicing SRA (*M* = 2.64) and CC (*M* = 2.30), but not CCSRA (*M* = 1.49). Although psychologists endorse cultural factors are important in SRA, they report little incorporation. Lastly, participants identified that insufficient training, few encounters with cultural minority clients, and a lack of knowledge about the effect of cultural factors on suicide risk, are all significant barriers to proper CCSRA.

Overall, we find similar effects from psychologists currently practicing as we did from trainees and trainers: there is insufficient and ineffective SRA training that is impacting clinician confidence and competence. Authors widely recommended that SRA training at the graduate level should be more prevalent, experiential, and driven by practice standards. These recommendations would likely work, too; we have sufficient evidence that training in SRA impacts competence (Kerr, 2019; McNiel et al., 2008; Suldo et al., 2010), decreases clinician anxiety (Ellis & Patel, 2012), and increases confidence (Dubue & Hanson, 2020; Suldo et al., 2010).

Psychologists' SRA Experiences

At the core of SRA is a suicidal client which, for many mental health clinicians, is not the same as working with other clients. As already reviewed, psychologists fear losing their client to suicide (Roush et

al., 2018) and the resulting threat of liability (Berman et al., 2015; Bruno, 1995). Yet, despite some psychologists having stigmatizing attitudes to suicidal clients (Brown et al., 2017), most psychologists feel knowledgeable and confident in assessing, treating, and managing suicide (Chu et al., 2017; Dexter-Mazza & Freeman, 2003; Erps et al., 2020; Gerardi, 2018; Liebling-Boccio & Jennings, 2013; Mackelprang et al., 2014; O'Neill et al., 2019; Roush et al., 2018). To best understand how psychologists practice and learn SRA, we must also understand how they experience (a) working with a suicidal client and (b) conducting SRA.

Experience Working with a Suicidal Client

For most mental health practitioners, working with a client with suicidal ideation is stressful (Maris, 2019; Shea, 1999) and, given the previously reviewed studies, psychologists see themselves as responsible for treating these individuals. In private practice, however, this responsibility is less strict; Groth and Boccio (2019) examined psychologists' willingness to accept clients with known suicidal ideation into their private practice, surveying their SRA training, attitudes, and perceived barriers. The authors randomly contacted 439 doctoral-level licensed psychologists within the United States who had a practice profile on PsychologyToday.com, recruiting a total of 89 participants (19.6% response rate). The mean age of the sample was 59 years old, with an average of 28.2 years practicing psychology. The authors created the 40-item Psychologist Attitudes Survey (PAS) for this study, measuring clinician's attitudes towards suicidal clients and their likelihood of taking them into private practice. Participants were first randomly assigned to review one of two vignettes describing either a suicidal client or a non-suicidal client. Here, 72.1% of participants exposed to the suicidal client reported they would take them, whereas 90.7% exposed to the non-suicidal client said they would take them. Said differently, 28% of participants indicated some unwillingness to accept a client with suicidality into their practice, with four factors explaining the unwillingness: (a) Liability/Discomfort, (b) Victim-Blaming, (c) Insufficient Readiness, and (d) Lack of Sympathy/Optimism; the higher the score, the greater the endorsement of

the factor. Since these factors have not been normalized or cross-validated with other measures, the authors refrained from making substantive conclusions about their results, electing instead to simply report their findings. The first factor, Liability/Discomfort, represented psychologists' feelings of nervousness and displeasure due to potential liability when working with clients at risk of suicide (*M* = 24.5 out of 42). Victim-Blaming measured psychologists' beliefs that clients with suicidality are weak, manipulative, and motivated by attention-seeking (*M* = 13.6 out of 42). Insufficient Readiness explored items measuring how psychologists feel unprepared to help suicidal clients, do not believe psychological services can be helpful, or are unaware of proper referral channels (*M* = 15.5 out of 42). Lastly, Lack of Sympathy/Optimism measured psychologists' lack of compassion for suicidal clients and belief they cannot live a normal life (*M* = 5.7 out of 21). Independent-samples t-tests revealed that participants high in Insufficient Readiness were more likely to reject the client with suicidal ideation (*d* = 1.2), whereas the other factors were not significant. Interestingly, although psychologists were mostly worried about liability when deciding to take a client with suicidal ideation, this did not affect their decision to take them. Only perceived competence in SRA and management was related to psychologists' willingness to treat someone with suicidal ideation.

Insufficient readiness, being the most predictive factor to reject a suicidal client in private practice, is an unfortunately common experience among health professionals. In Rothes and colleagues' (2014) examination of the difficulties psychologists (48%), psychiatrists (26%), and general practitioners (27%) face when working with a suicidal client, they found the most commonly endorsed difficulty was lack of preparedness. Across the 196 professionals surveyed, they frequently or very frequently said they lacked social support systems (48%), assessment instruments (47%), specific protocols (42%), time (31%), supervision (30%), and, ultimately, training (40%). Most of these characteristics were labeled as technical or clinical difficulties, which is unsurprisingly high in this sample considering over 80% of participants did not have any suicide training. As well, participants frequently or very frequently said

they were afraid about their client dying by suicide (38%) and struggled to work with the clients' family (30%). On a scale of 1 (not frequent at all) to 5 (very frequent), psychologists in this sample had an average of 2.6 on measures of logistics (e.g., lack of social support, lack of time), 2.4 on emotional difficulties (e.g., feeling burnout, ruminating about the case), and 1.7 on relational difficulties (e.g., being empathic with the client, dealing with the theme of death). The authors discuss how those with more training and exposure to suicidal clients ranked most of the difficulties lower, except for emotional difficulties, which was the same regardless of training. They suggest this does not mean training does not abate the emotional difficulties that come with working with a suicidal client, just that training does not focus on helping practitioners manage their emotional difficulties. These results are consistent with Groth and Boccio's (2019) findings, highlighting how a lot of the apprehension of working with a suicidal client is about competence and lack of training. They extend their findings by demonstrating that emotional difficulties are a problem, but is likely a normal and unavoidable one, and that the biggest barriers to clinician confidence and comfort are external (e.g., needing training, logistical). They recommend, like many others in the training section do, that to rectify these deficits, suicide training should be more plentiful, experiential, and active.

One of the parsimonious conclusions made by Rothes and colleagues (2014) and others (Maris, 2019) is treating suicidality becomes easier with experience. Dundas and colleagues (2022) queried this presumed effect empirically by surveying a representative Norwegian sample of psychologists (n = 375) about their experience, frequency of contact, and perceived difficulty of working with suicidal clients. Most participants were women (72%) who worked in secondary mental health services (57%), completed a mean of 14 sessions per week, and have been working for a mean of 15 years. They found the perceived difficult of working with suicidal clients was lower as their years of professional practice ($r = -0.13$) and frequency of working with suicidal clients ($r = -0.15$) increased. Said differently, experienced and older psychologists found suicidal clients easier to work with. Although these effects were

significant ($p < .01$), they were weak, accounting for 1.7% and 2.3% of the variance, respectively. The authors elaborated on their results by thematically analyzing an open-ended question that asked participants about the most difficult part of working with suicidal clients. Psychologists here noted suicidal participants were often emotionally or logistically unreachable (e.g., unable to hope-build or contact through phone), that suicidal clients would impede on their boundaries (e.g., calling them at night), or that they struggled to empathize with the desire to die. Another theme centered around the psychologists' difficult choice of choosing between therapy and security, where participants wrestle with the responsibility of providing therapeutic gain while keeping their client safe, which they note is often in contest with one another. The authors agreed that working with the aforementioned assumption; more experience and exposure to suicidal clients does make the psychotherapy process easier. However, they discuss how their results suggest that time and exposure is not enough to reliable increase therapists' confidence, particularly when psychologists are in the dual role of clinician and safety assessor. As such, they recommend suicide training be a repeated, deliberate practice that focuses on exposure to the difficult emotions experienced while working with a suicidal client, arguing this process would minimize the risk psychologists would have an arousal response during such contentious encounters. They note this has already been successful with psychiatrists (Silverman & Berman, 2014b) and is already built into collaborative SRA and management models (Jobes, 2012).

Part of understanding the experience of working with suicidal clients is also understanding practitioner's attitudes towards suicide itself. Osafo and colleagues (2012) qualitatively examined attitudes towards suicide in nine clinical psychologists and eight emergency ward nurses in Ghana. Participants were recruited through a purposeful, snowball, and self-selected sampling strategy. Seven psychologists worked in private practice and two in a general hospital, all of whom have master's level education and four had a Ph.D., with clinical experience ranging from three to forty years. The authors used Interpretative Phenomenological Analysis to conduct and analyze the interviews, from which four

themes emerged: (a) Suicide: Pathology or a Moral Issue? (b) Between Care and Crime, (c) A Needful or Blameworthy Person? and (d) Prevention: Health Services and Proscriptive Approach. Although the themes were generated using the whole sample, the authors reported discrepancies between the psychologists and nurses; I will prioritize reporting on the psychologists' results. In the first theme, younger psychologists (*n* = 4) reported more judgement towards suicide, such that suicide is a sin according to their religion or morality, whereas older psychologists (*n* = 5) saw suicide as a mental health issue. In the second theme, Between Care and Crime, all psychologists believed society's response to suicide should be through treatment, rather than criminalization, recognizing that individuals with suicidal ideation are unwell and vulnerable. In the third theme, A Needful or Blameworthy Person, psychologists reported those with suicidal ideation are in need, often using empathy to understand and inform treatment. Lastly, in the theme of Prevention: Health Services and Proscriptive Approach, psychologists identified suicide prevention was possible due to client ambivalence towards death, and that, paired with the belief that suicide is an illness, education and mental health care are needed in response to a suicidal patient. This study, overall, reflects an increasing gain in psychologists and mental health workers' shift from a moralistic attitude regarding suicide to one of empathy and emphasis on mental health treatment, which is consistent with most other psychologists' attitudes towards suicide (Dubue & Hanson, 2020; Gagnon & Hasking, 2012; Hammond & Deluty, 1992; Kodaka et al., 2011)

A consequence of psychologists' empathic view of suicidal clients is that they are more vulnerable to experiencing grief, should the client die by suicide (Skodlar & Welz, 2013). Finlayson and Graetz Simmonds (2018) examined the impact of client suicide on 178 Australian psychologists, with a questionnaire measuring the frequency and experience of losing a client to suicide. Participants in this study were mostly clinical psychologists (55.1%) who worked in private practice (56.7%), were early to mid-stage career (1-10 years of service; 58.4%), and had a master's level education (48.3%). Of those participating, 31.5% had lost a client to suicide, with the incidence being higher in those with longer

years of service. Participants reported sadness, shock, and helplessness as the most intense emotional responses post-client death, which lasted between one week and one month (40.7%). Participants who felt responsible also felt distress (*r*=.29), guilt (*r*=.74), shame (*r*=.53), shock (*r*=.29), confusion (*r*=.35), helplessness (*r*=.29), and incompetence (*r*=.62), and those who believed the suicide was predictable did not feel shock (*r*=-.30) or confusion (*r*=-.33). Regarding the lasting impact of a client's death by suicide, psychologists reported more caution with "at risk" clients (66.1%), increased attention to legal aspects of their practice (60.7%), increased focus on suicide cues (57.1%), and increased consultation with peers (57.1%). As well, most participants who have lost a client to suicide doubt their practice competency in SRA (48.2%). Participants coped with the loss by talking to colleagues, working to let go their perceived responsibility, and increasing their acceptance of the death. The authors emphasize these results indicate psychologists deserve SRA training that destigmatizes this experience, better support from supervisors, and a better understanding about the unrealistic predictability and preventability of suicide. They also highlight the impact depth and length a client's death by suicide can have on psychologists, which is colloquially understood as an inevitable occupational hazard (Chemtob et al., 1989).

Delving deeper into this experience, Darden and Rutter (2011) interviewed six clinical psychologists who had experienced a client's death by suicide and analyzed the results under the guidelines of Consensual Qualitative Research (CQR; C. E. Hill et al., 1997). Recruited through convenience and self-selection, participants had been practicing for an average of 12.5 years at the time of their client's death by suicide, where one worked in a university counselling center, two in private practice, and three in a hospital setting. The clients who died by suicide were all male, with ages ranging from 18 to 44. The CQR analysis team comprised of the interviewer, two judges, and an auditor, all of which were master's graduates or doctoral students in counselling or clinical psychology. Notably, none of the members of the research team had previously experienced a client's death by suicide. Five of the six participants were also contacted after the interview for clarification and increasing the depth of the

interviewer's understanding of their experiences. The authors report six domains: (a) Psychologists' View of Suicide, (b) Clinical Aspects of the Case, (c) The Suicide, (d) Impact, (e) Recovery, (f) Client's Family. In the first domain, Psychologists' View of Suicide, participants endorsed the prevention of suicide as central to their work, although considered it beyond their control. In the second domain, Clinical Aspects of the Case, psychologists describe how assessing for risk played a significant role in their perception of their client's safety, often identifying how, prior to the client's death, the psychologist believed their symptoms were improving. The third domain, The Suicide, described how psychologists explain their clients' death, highlighting how administrative decisions (e.g., early discharge) were prioritized over clinical ones (e.g., symptom regression). Further, participants reported hearing about their clients' death through a peer or supervisor, rather than finding out themselves. The fourth domain, Impact, describes the differences among psychologists' grief process; when queried, some participants spoke only about the impact on the clinic, some primarily spoke about what they missed in the SRA, and others worried that those in their personal lives would see them as a failure. Further, all participants endorsed a subsequent hyper-vigilance to suicide after their loss, often endorsing stricter and more elaborate SRAs. The fifth domain, Recovery, described how psychologists sought to cope by talking with supervisors, peers, spouses, although those in private practice or without a supervisor felt isolated. The last domain, Client's Family, described how psychologists did not have much contact with the family post-client death, either being counselled to avoid the contact for legal reasons, or because the family did not contact the psychologist, despite previous involvement in treatment. In their conclusion, the authors describe the experience of psychologists as harrowing, buffered only slightly by having supportive peers or supervisors. They highlight how psychologists felt the death was both outside of their control, while also ruminating about what they missed in the SRA, ultimately leading to more hypervigilant and paternalistic SRAs and interventions. All this, they note, is

part of the fear experienced when first working with a suicidal client, which is consistent with other literature on the topic (Gulfi et al., 2016; Scupham & Goss, 2020).

Once a client reports a risk of suicide, clinicians are likely to feel more stressed, fret about emotional and logistical resources, question their readiness, fear the risk of liability, and worry about how they will prevent their client's death, and the consequences if they fail. All this, and psychologists are instructed to immediately conduct an SRA. Invariably, how psychologists view suicidal clients and understand their treatment affects their first, and very critical, interaction.

Experience Conducting SRA

Despite this multifactorial and complex experience, there is very little literature examining how clinicians experience that first interaction of conducting SRA. To date, there is only one study examining psychologists' experiences, which is my master's thesis project (Dubue & Hanson, 2020). Here, we recruited and interviewed five psychologists in Canada to explore their experience of conducting SRA including understanding how they view suicidal clients, how they are affected by SRAs, and how they view their training. We used Interpretative Phenomenological Analysis (Creswell et al., 2007; J. A. Smith et al., 2009) to guide the interview protocol development and theme analysis and found nine themes. The first, and overarching theme, was that psychologists were often in conflict with themselves during SRAs, as they were weaving assessment and therapy into the same practice. They described how, when suicidality was endorsed, they shifted from a therapeutic stance to an assessors', and that the goals of each were often in conflict (e.g., providing dignifying treatment vs. breaking confidentiality to report on their suicidality). This conflict was seldom reconciled and was responsible for the lion's share of their distress during SRA. Regarding the other themes, psychologists often invested a disproportionate amount of emotional and logistical resources in their clients and assessed their risk by mostly relying on their clinical intuition. Attitudes-wise, psychologists here had a positive view of suicidal clients, often understanding that suicidality was a product of psychosocial distress and not a weakness or illness. They

also understood that suicide is typically a rationalization of how to end overwhelming distress, and that it was important, and possible, for them to intervene. Psychologists further identified that their fear of liability and client suicide was one of the main reasons they practiced SRA, often having difficulties managing the balance between maximizing client benefit (e.g., respecting their autonomy) and minimizing harm (e.g., preventing them from dying by suicide using paternalistic measures like hospitalization). Psychologists also reflected that their SRA practice is setting-dependent, noting the heightened risk aversion in private practice, institutional requirements in public practice, and the pressure from coworkers to practice equivalent SRAs. Lastly, participants overwhelmingly reported their graduate training was inefficient and insufficient, and that they learned most of their SRA practice either from previous volunteer work, practica, or post-graduate professional development. We concluded that psychologists have experiences during SRA that are like other mental health professionals, as both wrestle with ethical conflicts, have added stress, and deal with a higher resource demand, all while feeling under-trained. However, psychologists are dissimilar in that they are seldom working in interdisciplinary teams, do not have legislative authority to hospitalize a client, and have more time to develop deeper and more vulnerable therapeutic alliances with our clients. These latter differences, make the process of SRA more agonizing for psychologists, as they are often called to undermine their most effective tool to treat suicidality for an unreliable chance that they can keep our clients alive (Martin et al., 2000; Truscott, 2021; Wampold, 2015).

As discussed in my study, formulating a client's risk of suicide is complex, fraught with competing interests, and idiosyncratic. One laboratory out of Toronto has been investigating these high-risk mental health decision making processes through vignettes (Regehr et al., 2016), simulated interviews, education, and real-world monitoring (Regehr et al., 2022b), and broader conceptual inquiries (Regehr et al., 2021), ultimately agreeing that the process of conducting and acting on SRAs is multifaceted. Regehr and colleagues (2022a) aimed to understand this complexity by investigating how

mental health practitioners conduct, experience, and act on SRAs through the laborious method of grounded theory (Glaser & Strauss, 2009). Here, they recruited 13 social workers, nurses, and occupational therapists from a large mental health facility with three or more years of clinical experience and asked them to complete two SRA interviews through an Objective Structured Clinical Examination (OSCE), which is an actor-facilitated realistic simulation. At the end of the client interactions, participants were asked to state their clinical impressions, determine a risk level, say whether they would recommend hospitalization, and then complete a standard measure of SRA used in their workplace. They also collected self-reported stress, as measured by the State-Trait Anxiety Inventory (Spielberger, 1983), and continuous heart rate variability, as measured by a small chest-strapped monitor with two electrode patches. Lastly, they had participants review their SRA OSCE through video recording and transcripts, asked them about their decision-making processes, and participated in four group discussions on their decision-making. The authors first validated the OSCE manipulation, finding that participant heart rates and subjective stress were appropriately elevated, which was consistent with participants' self-report about the authenticity of the interviews. Regarding risk appraisal, they found participants diverged greatly from one another in both risk scores and recommendations, which was not helped using a standardized SRA. In using this SRA tool, participants reported they were highly knowledgeable of how to use it and were experienced in doing so. However, they also noted limitations, evidenced by some participants saying they make their risk decisions well before they use the SRA tool, often leading to fluid decisions that are adaptive to what is happening in the room with the client. The authors delved deeper into this fluidity, finding that practitioners relied heavily on their professional experience, risk tolerance, and organizational and team factors, all of which they kept in mind while editing and making a risk formulation. Participants were more comfortable with this fluid SRA process than standardized ones, as it gave them a chance to incorporate emerging information and better connect to the client. They also noted that the SRA tool, even though it may not

be relevant to their decision-making, was sometimes used to manage uncertainty and deflect responsibility, similarly to how psychologists in my study discussed using SRA to manage their fear of liability (Dubue & Hanson, 2020). Combining these reflections, the authors developed their theory of how clinicians engage in SRA and complex decision-making. They posit a recursive linear model that begins at clinicians assessing static information (e.g., risk factors, chart notes), then probing dynamic factors (e.g., client's explanation, contextualizing the data), and then drawing on their clinical judgement and experience to formulate a risk level. In their theory, the clinician then integrates this information into a judgement (e.g., safe or not safe) which starts off the second half of the decision-making process: deciding how to intervene. Here, practitioners consider team dynamics, organizational constraints, and resources to determine how to best prevent suicide (e.g., hospitalization, safety planning, community follow-up). The authors discuss how their theory highlights how most SRA decision-making processes have relied too heavily on individual teaching and responsibility, and that clinicians are often deciding on suicide prevention interventions based on external resource availability. As a result, they argue that community- and hospital-based services stand to provide the greatest benefit to suicidal clients, compared to individual clinician education. They conclude with a summary of their collective work, highlighting that their results show the nature of risk decision-making is influenced by personal and professional experiences, including organizational and social contexts, and that these personal and social processes often overwhelm efforts to standardize and simplify (Regehr et al., 2021).

These acute community and hospital resources are, indeed, where suicidal clients are likely to find themselves (Pfeiffer & Strezelecki, 1990; Ringel & Sturm, 2001). Hagen and colleagues (2017) aimed to better understand how clinicians care for suicidal clients in these settings. They recruited Norwegian psychiatrists (n = 4) and psychologists (n = 4) whose professional experience ranged from 2 to 30 years, with six having more than 10. Using a semi-structured interview process, with analysis guided by thematic analysis (Braun & Clarke, 2006), the authors found three main themes: (a) emphasis on

categorizations of suffering and suicidality, (b) limited direct care of suicidal patients, and (c) fragmented mental health services. The first theme describes how clinicians prioritize assessment and categorization of patients based on perceived risk level and chronicity of suicidal ideation. This usually meant spending a large portion of time on SRA and emphasizing an information-gathering approach rather than a relational one, which appeared to be a demand of the institution. Clinicians routinely questioned this approach and worried that their emphasis on categorization would harm their ability to connect to their client. They lamented the responsibilities issued by health authorities on their SRA practice and believed SRA was mostly for liability insurance. The second theme, limited direct care of suicidal patients, described how participants only had a few opportunities to meet with patients with suicidal ideation before discharge. The participants highlight how, due to the risk of suicide, administrative responsibilities (e.g., case notes, reports to peers) often fills the space where more one-on-one interventions could occur. Lastly, the theme of fragmented mental health services describes how participants dealt with multidisciplinary units, health professionals, and regulations when working with a patient with suicidal ideation. Participants noted frustration as patients were being moved repeatedly through outpatient and inpatient settings, often in different wards, making it difficult to build a stable connection. The authors concluded by reiterating the dual roles that therapists must adopt when conducting SRA; that they both need to ensure their client's safety while treating their distress with dignity, which, in perceived high-risk situations, can be oppositional. And, as much as practitioners disapprove of the system's risk assessment requirements, they contribute to a sense of self-protection in both anxiety and liability. Interestingly, the experiences of clinicians in these acute settings are still very similar to those in outpatient or community settings.

These conflicting dual roles invariably cause clinicians stress, which a wealth of reviewed literature suggests is mitigated by experience and confidence (Dubue & Hanson, 2020; Regehr et al., 2016; Silva et al., 2016; Suldo et al., 2010). Airey and Iqbal (2022) aimed to better understand this

phenomenon through a systematic review of the literature. They identified 192 papers, with 10 meeting their review criteria, most of which were written from Canada (*n* = 1), United States (*n* = 5), and the United Kingdom (*n* = 4) and encompassed a wide range of health professionals (e.g., clinicians, mental health professionals, frontline staff). They found that over 50% of clinicians were confident in their SRA formulation and that this confidence is often increased following suicide-related training. The authors note that this confidence is slightly unwarranted, arguing that many clients who die by suicide were in contact with a clinician a year prior to their death (Luoma et al., 2002). They posit that clinicians are overconfident in their SRA practice, either because confidence can buffer against the uncertainty present when working with a suicidal client, or because of a methodological social desirability effect. The authors conclude by first stating that the quality of the literature around SRA and confidence is lacking rigor, particularly due to small sample sizes, emphases on self-report, and methodologies that are not consistent with actuarial practice. They recommend that clinicians be aware of the misleading effects of overconfidence and researchers examine more closely the relationship between confidence and competence.

The experience of conducting SRA is, overall, a disproportionate challenge. Like the experience of working with suicidal clients, clinicians report feeling more stress, using more personal and institutional resources, and fear the consequences of failing to meaningfully connect with them. However, SRA poses additional difficulties. It places clinicians in this double bind where they are told to simultaneously protect their client's safety and respect their autonomy, messages that are at the conflictual epicenter of SRA. Given institutional and perceived ethical requirements, clinicians use SRA tools to abate this conflict and deflect their responsibility, even though they know SRAs are not informing their decisions nor are they useful to their clients. Clinicians thereby find themselves caught in a recursive and fluid decision-making process where they wrestle with static and dynamic client factors, their own personal biases and experiences, and the availability and quality of community resources to

best attend to their suicidal client. Indeed, the affect experienced by clients has a direct impact on the suicidal client's narrative, including how they understand their distress and their hopefulness to relieve their pain (Ying et al., 2021). However, in this process, the client is left behind, often just a subject of assessment rather than a collaborative investigator of their own distress. It is imperative that we better understand how clinicians practice, learn, and experience SRA, such that we can update our training to match our current understanding of suicidality and better attend to our most neglected factor: the person who wants to end their pain.

Gaps in the Literature

There are four main problems in the SRA practices, training, and experiences literature: (a) most SRA practices literature risks a social desirability bias, (b) most multidisciplinary literature aggregates psychologists among other mental health professionals, (c) the reviewed qualitative studies had few measures of quality and trustworthiness, and (d) the benefits of mixed methods research are underutilized, particularly for a complex topic like SRA.

Firstly, the validity of more SRA practices literature is held back by a significant risk of social desirability. Social desirability bias is defined as the tendency for survey users to answer in ways that are self-promoting or viewed favourably by peers (Grimm, 2010). This common source of bias can be dealt with in a two main ways: (a) include a social desirability scale/item, (b) implement survey design techniques that reduce bias (e.g., forced-choice items, bogus pipeline, open-ended question) (Nederhof, 1985). Unfortunately, none of the reviewed surveys included such measures, which might undermine the validity of the actuarial SRA practices by psychologists. In fact, nearly all the survey designs addressing the topic of SRA practices used a checklist or Likert-like survey (Bruno, 1995; Higgins et al., 2016; Rothes & Henriques, 2018; Roush et al., 2018; Rozek et al., 2022) which was author-developed. The only one study differed in assessing SRA practices, which was the open-ended question design of Love and colleagues' (2020) study of family and marriage therapists. Here, they asked participants to

reflect and respond to their brief vignette and question: "You have an individual client in session that expresses an intense wish to die and means to do so. Please explain the steps you would take in the session and following the session to reduce this client's risk of dying." They subsequently coded their responses which, albeit significantly more labourious than a Likert-like survey or checklist, is presumably closer to the actuarial SRA practices of their participants. And, more importantly, this approach reduces the risk of social desirability in that there is no checklist/reminder of what SRA practices exist for participants to review and, perhaps, falsely endorse or overestimate. This is especially important in SRA research because clinicians are disproportionately fearful of the consequences of improper SRA which may push them to endorse as many behaviours as possible, rather than report their actual practice, to seem more ethical and compliant.

The aggregation of psychologists into the "other/allied health professionals" category in SRA research is also problematic. A wealth of qualitative studies (Aflague & Ferszt, 2010; Awenat et al., 2017; Dubue & Hanson, 2020; Michail & Tait, 2016; Petrik et al., 2015; Roy et al., 2017) highlight how psychologists differ from other health professionals in their attitudes, training, time investments, responsibilities, and competence in SRA. As well, these interdisciplinary sampling approaches often recruit psychologists who practice in medical settings, which albeit important to understand, is not representative of most psychologists who practice privately, limiting the generalizability of the results. Further, even when aggregated with other mental health professionals (e.g., mental health therapists, mental health nurses, clinical social workers, marriage and family therapists, or counsellors) the training standards, expected responsibilities, and resulting experiences can be significantly different. A good example is the sampling diversity of Jahn and colleagues' (2016) research where they studied the comfort clinicians had working with suicidal clients across measures of training, fears, and exposure to suicidal clients. They note that their findings are limited by the heterogeneity of their sample, as some professions (e.g., psychologists) have doctoral-level education and plenty of supervised exposure to

suicidal clients compared to others (e.g., chemical dependency counsellor) who have a master's education or less, may not be explicitly trained in mental health, and have less supervised exposure to suicidal clients. Some authors, such as Rothes and Henriques (2018), avoided the issue of heterogeneity by segregating and reporting the results according to each of the three professions in their sample (psychologists, psychiatrists, and general practitioners). Recognizing these professional distinctions in study design is important, especially when this kind of evidence is used to inform practitioner training.

In the reviewed qualitative designs, practices of quality and trustworthiness were scarce. Only a minority of these studies included an audit trail, peer reviews, sample analyses, conducted member checks, or included a "researcher-as-instrument" section, whereas most did not include any mention of quality indicators. This undermines the trustworthiness of their results. However, the qualitative studies did vary in methodology, representing Thematic Analysis, IPAs, systematic text condensation, phenomenological reflection, qualitative content analysis, and CQR designs. This is impressive, as a diversity of qualitative methodology that produce comparable results can be seen as rigorous and reliable (Creswell & Poth, 2017).

Lastly, as of this review, there is no mixed methods research (MMR) on SRA practices, training, or experiences. Some studies included in this review were MMR misnomers, in that they collected quantitative and qualitative data (e.g., Likert-like survey questions and open-ended question), but they did not engage in the fundamental defining feature of MMR which is integration (Creswell & Plano Clark, 2018). Although integration can be the combination of any methodology or approach (Creamer, 2018), the underlying principle in integration is that it is explicitly identified in the procedures and results, resulting in inferences that are greater than the sum of its parts (Fetters & Freshwater, 2015). This includes having MMR question(s), explicitly stating what parts are integrated, developing a procedural diagram with integration identified, and using joint displays or visuals which merge and connect the results (Guetterman, 2019; Plano Clark, 2019). The lack of MMR in suicidology, however, is not new; 10

years ago, Rogers and colleagues (2010) argued that research and knowledge development in suicidology required a shift away from mono-method research designs. In its stead they offer MMR, as it better captures the phenomenological, epidemiological, sociological, and psychological facets that are required to fully understand suicide. Throughout the studies reviewed, when discussing their limitations, most identified that their topic of study had complexities that could not be measured by just a survey or identified through interviews. MMR is about "letting the messiness and complexity of the world speak" (Uprichard & Dawney, 2019), which accurately describes any inquiry into SRA. For example, the reviewed studies indicate psychologists are competent in SRA and practice it frequently, yet feel anxious, worry about liability, and desire more training. An MMR study, in this case, could have linked these two findings, exploring and explaining this important effect.

The present study aims to fill these content and methodological gaps. As described in the next section, this study intentionally tries to reduce social desirability bias and better assess the actuarial practices of psychologists by using an open-ended question design, focuses uniquely on psychologists, discusses qualitative trustworthiness and quality, and uses a MMR design to explore and explain the complexity of SRA. Importantly, the present study is consistent with calls to action and future directions from researchers, practitioners, and policy makers, such as The Lancet: Psychiatry (Holmes et al., 2018), the American Psychological Association (Franklin et al., 2018), and Canada's (The Government of Canada, 2016), Alberta's (Alberta Mental Health Board, 2009) and Edmonton's Suicide Prevention Strategy (Edmonton Suicide Prevention Advisory Committee, 2017), all of which call for an in-depth inquiry into how mental health care workers are practicing, learning, and experiencing SRA.

Chapter III: Methods

This section is ordered in the same way the data was collected and analyzed, which followed the sequential explanatory mixed method structure. I begin by describing the survey procedures (quantitative methods), followed by the interview procedures (qualitative methods), and their integration. Figure 1 is a Gantt chart of these procedures.

Survey Procedures

Survey Design

The survey development process is detailed in Appendix 1. The survey (Appendix 2) is divided into six sections: (a) Inclusion Criteria, (b) Practices, (c) Training, (d) Experiences, (e) Demographics and (f) Follow-Up Interview Consent.

The first section checks that participants meet the inclusion criteria listed in the consent form. Two questions make up this section, asking if the participant is a registered psychologist in good standing with their provincial regulating body and if they have conducted suicide risk assessments within the last 10 years. I included the latter inclusion criteria to capture participating psychologists that may be registered with their provincial licensing body but have not conducted SRAs or practiced in a while (e.g., Industrial/Organizational Psychologists). As well, the 10-year time range was intended to capture participants who may have practiced SRAs in the past but are currently in administrative or teaching roles.

The second section, Practices, measures how, and the frequency by which, psychologists practice SRA. All three questions were adapted from other SRA practice studies. The first two questions were adapted from Roush and colleagues (2018), who assessed mental health professionals SRA practices; I modified their question on assessing frequency of assessment into two separate questions (general SRA frequency and new client/screening frequency) and modified the response scale to suit the current study. The final question was a short-answer question asking: "In a one-on-one psychotherapy

session, a client tells you they are thinking of dying by suicide. Step-by-step, what do you do?" I developed this open-ended question to fill a methodological gap, as discussed in the previous chapter. When I first developed this question in July 2020, I had not found any study that used an open-ended format to assess how mental health practitioners respond to a suicide disclosure. I only found two comprehensive measures of SRA practices: the Intervention Strategies towards Suicide Behaviours Questionnaire (ISBQ; Rothes & Henriques, 2018) and an unnamed questionnaire (Higgins et al., 2016). They were inappropriate for this study for three reasons. First, the 39-item ISBQ was developed for general mental health practitioners, whereas Higgins and colleagues' (2016) questionnaire was normed on mental health nurses, both of which spend several items assessing how their SRA practice is affected by co-health care workers (e.g., medical doctors, psychiatrists). Second, the surveys are lengthy (40+ items) and wordy. Lastly, and most importantly, listing every possible SRA practice risked social desirability bias or demand characteristic effects, such that participants overreport SRA practices because they are listed. An open-ended short-answer question addresses these concerns while introducing more content validity to the responses; for example, when a suicide risk arises in a client session, it is often up to the clinician to spontaneously generate their response strategy. Open-ended responses are more likely authentic to the actuarial SRA practices of psychologists in Canada. As of this review, I am aware that this question mimics the design of Love and colleagues' (2020) SRA practices question for marriage and family therapists, although we worded them slightly differently.

The third section, Training, measures the frequency, type, and satisfaction of participants' SRA training. The questions were based on a dissertation survey assessing internship-ready professional psychology graduate student's SRA competency and attitudes (Kerr, 2019). Here, participants were asked if, where, and what kind of SRA training they received, what SRA training influenced their practice the most, their satisfaction in their graduate SRA training, confidence in their current SRA practice, and desire for more SRA training.

The fourth section, Experiences, measures how psychologists experience SRA. These items were primarily derived from the findings of my qualitative master's thesis examining psychologists' experiences conducting SRA (Dubue & Hanson, 2020), which are summarized in Table 1. Twenty-two Likert-like questions and two short-answer questions make up this section across five subsections. The first subsection, Weaving Assessment and Therapy, measured the priorities of psychologists when they conduct an SRA. To avoid a social desirability effect, I elected to use a short-answer question asking: "What is your priority when conducting a suicide risk assessment?", instead of listing the various aims, goals, or priorities present in SRA. The second four-item subsection, Relying on Clinical Intuition, measured the degree psychologists trust their own judgement when determining a risk level for suicide. The third eight-item subsection, Investing in the Suicidal Client, measured the degree to which psychologists spend personal and professional resources into their risk assessment and management of their clients with suicidal ideation. The fourth five-item subsection, Fear of Client Suicide Drives SRA, measured the belief and consequential fear psychologists harbour towards a client's death by suicide and how an SRA may help alleviate that fear. The last six-item subsection, The Pressure of Responsible Caring, measured the intersection of ethics and suicide prevention in psychologists' SRA experience.

The fifth section, Demographics, measured the demographics of the participant, including gender, age, education, cultural background, practice setting, and theoretical orientation. It was adapted from Jacobson and colleagues (2015) and modified according to feedback received during the survey development.

The sixth and last section, Follow-Up Interview Consent, asked questions related to the participants' interest in participating in a follow-up interview. This included information regarding consent and procedures.

Survey Collection

The survey was hosted on Qualtrics (2020), an online survey and market research website, with assistance provided by the University of Alberta's Information Services and Technology division. The results were collected through end-to-end encryption and stored on a Canadian server on the Qualtrics domain. I ensured proper data storage, protection, and anonymity by concurrently downloading the survey results onto an external hard drive, which was password protected on both Windows login and hard drive access and locally encrypted through Windows encryption software. These data were concurrently backed up on a separate hard drive stored within a locked cabinet within a locked room, in a separate location from the original hard drive. Once survey data collection was complete and locally transferred, I deleted the information from the Qualtrics domain. After accessing the survey through the anonymous survey link, participants were presented with an abbreviated version of the consent form (Appendix 2), including a link to the full version (Appendix 3). Participants were asked if they agreed to participate in the study, that they had read and understood the consent form, and desired of their own free will to participate prior to beginning the survey. The final question of the survey asked about the participants' interest in participating in a follow-up 30-minute phone interview to better understand their survey answers. If participants endorsed an interest, they were sent to an abbreviated version of the follow-up interview consent form that included a link to the full version (Appendix 4). If they agreed to participate, they were asked for their email address for the purposes of follow-up contact.

Survey participants were recruited through purposive and snowball sampling from five sources: (a) Canadian Psychological Association (CPA), (b) Provincial Regulatory and Societal Bodies, (c) University Programs & Residencies (d) CPA Sections, and (e) social media.

Through the CPA, the survey link as well as a recruitment message was posted on their social media (e.g., Twitter, Facebook) twice over a one-month period and on the Recruit Research Participants Portal (R2P2) for four months. Approximately 10 participants were collected through this source.

Following recruitment through the CPA, I contacted most of the Regulatory and Societal psychological bodies that govern or advocate for psychologists in Canada querying research participant recruitment. I connected with 19 organizations, nine of which either posted the recruitment information on their webpage for one to three months or emailed their membership with a recruitment message and letter. The recruitment letter can be found in Appendix 5 and a summary of which organizations were contacted, and the outcome, is described in Table 2.

Concurrent with the former recruitment source, I contacted the Directors of Training of CPA-Accredited Counselling and Clinical Psychology programs and Pre-Doctoral Internships/Residencies in Canada. Eleven of the 38 (29%) CPA-Accredited programs and four of the 49 (8%) CPA-Accredited Pre-Doctoral Internships/Residencies returned to me a confirmation that they had sent it along to fellow faculty members or relevant listservs.

At this point in recruitment, I still had not reached my desired sample size and thereby contacted the section chairs of the relevant CPA sections (16 out of 32 sections). Out of the 16 relevant sections, seven (44%) returned to me confirmation that they had either sent it to their listserv, included it in their upcoming newsletter, or both. Importantly, both the Clinical Psychology and Counselling Psychology sections sent out an email with the recruitment information to their membership twice.

Lastly, I connected with various organizations, social media groups, and psychologists in the community who could share my study with their colleagues or groups. Organizations included the Canadian Mental Health Association, the Center for Suicide Prevention, the Ottawa Academy of Psychologists, and the Canadian Association for Suicide Prevention. Social media groups included Psychologists in Private Practice Community – British Columbia, Montréal Psychologists, Saskatoon Psychologists, and Alberta Psychology, among others.

Survey Translation

Near the end of recruitment, preliminary analysis revealed the sample recruited was not representative of psychologists practicing in Québec. To better reach these participants, I first translated the survey into French. To validate the accuracy of the translation, I contracted a McGill Ph.D. Candidate in Counselling Psychology who owned their own translating business and specialized in working with researchers in psychology-related fields. The translator cross-checked the English and French versions of the survey for consistency in meaning and reviewed supporting documents. The French version was integrated into Qualtrics where participants could change the language at any point in the survey (Appendix 6).

Survey Participants

Three hundred thirteen participants responded to the online survey, 160 of which provided complete data. Of the 153 participants who did not complete the survey, 62 self-reported not meeting inclusion criteria, 69 met criteria and consented to the survey but did not complete any of the following questions, 12 completed up to the long-answer SRA Practices question, and 10 had varying amounts of incomplete data (see Figure 2 for a Sankey chart).

All survey participants were registered or licensed psychologists currently practicing in Canada who were in good standing with their provincial or territorial regulatory body. These participants had all conducted SRAs with clients/patients within the last 10 years, with SRA being defined as "the act of discussing, determining, or monitoring a person's risk of dying by suicide". Survey participants were predominantly White/European Canadian (90.0%) women (80.6%) with a Ph.D. (61.9%) who practiced privately (39.4%) primarily using a Cognitive Behavioural theoretical orientation (45.6%) (Table 3). A relatively equal majority of participants practiced in either Alberta (19.9%), Ontario (23.3%), or Québec (19.9%) (Table 4) and had expertise or were affiliated with the CPA section of Clinical Psychology (30.1%) (Table 5). This sample proportionately represented all provinces, with the possible exception of Québec. Although the survey was translated into French and we sent another recruitment email to French-

speaking members of multiple previously contacted organizations, our final sample was not representative of Québec practitioners when compared to the data collected by the Canadian Institute for Health Information (CIHI, 2020) (Table 4). However, our sample was representative when compared to studies that recruited psychologists in Canada (Jacobson et al., 2015; Ronson et al., 2011).

Survey Analysis

The survey data analysis was divided into two components: (a) frequency analysis of the close-ended questions using SPSS (IBM Corp, 2017) and (b) the manual coding of the open-ended questions. Regarding the latter, there were seven open-ended questions in the survey that required manual coding, one in the Practices section, four in the Training section, and one in the Experiences section. The first (Question 7 in Practices: "In a one-on-one psychotherapy session, a client tells you they are thinking of dying by suicide. Step-by-step, what do you do?") was manually coded on 26 categories that were multiple choice (e.g., was the response quality limited, appropriate, or thorough?) and binary (e.g., did the response mention risk factors?). The categories were developed based on the ISBQ (Rothes & Henriques, 2018), and two unnamed SRA practice questionnaires used in Higgins and colleagues (2016) and Chu and colleagues (2017). A full list of the coding system and category descriptions is in Appendix 7.

Questions 2, 4 (a & b), 5 (a & b), and 8 in the Training section asked short-answer questions. Question 2 asked about what kind of SRA training participants had completed, with 23 indicating "other". Seventeen of these answers were recategorized into their proper categories (e.g., if they said ASSIST, I recoded it as professional development), and the remaining 6 were reclassified into a new category "Post-Doctoral Year". Questions 4 and 5 asked what kind of professional development or self-directed learning, respectively, participants had completed, as well as what made them pursue these extracurriculars. Question 8 followed up from a previous question, which asked which training was the most influential, with Question 8 asking for a short description as to why it was the most influential. For

Questions 4, 5 and 8, I reviewed participants' answers, inductively developed categories that grouped them, and subsequently coded the answers using a multi-response coding scheme (see Appendix 8).

The last question (Question 1 in Experiences: "What is your priority when conducting a suicide risk assessment?") was manually coded on two categories (What was the first priority and what was the second priority?), both with the same response set (Assessing Risk, Safety, Therapy/Treatment, Connection/Empathy) (see Appendix 9).

I enlisted the assistance of a Ph.D. student in Counselling Psychology at the University of Alberta who also studies suicidology (from here on titled "co-investigator") to aid with the coding. Prior to coding, we completed a researcher-as-instrument journal entry detailing our experience of SRA and discussed biases that might arise in the coding process. I reviewed each question and developed a coding scheme, which I then edited according to feedback from the co-investigator. For questions 7 of Practices and 1 of Experiences, we coded the responses independently, conducted reliability analyses, then discussed and resolved discrepancies. For questions 2, 4, 5, and 8 of Training, I coded the responses which my co-investigator reviewed independently and provided feedback.

Interview Procedures

Interview Protocol

Consistent with an explanatory sequential mixed methods design, the next phase of the study was to develop follow-up research questions (FURQs) for the interview that expanded upon the survey answers. First, I summarized the survey answers as codes and placed them on a blank map in Atlas.ti (Scientific Software, 2012). I grouped these quantitative findings using principles from thematic analysis (Braun & Clarke, 2006) and, iteratively with a literature review, I developed the first draft of the quantitatively-informed qualitative FURQs. I included 21 FURQs in this initial draft and shared them with the co-investigator. Together, we identified eight FURQs that we believed were the most consistent with the original research questions. From these research questions, I developed the follow-up interview

questions and implemented editorial feedback from my co-investigator, graduate student colleagues, practicing psychologists, and my supervisory committee. All 21 FURQs, their associated quantitative findings, the interview questions, and the rationale for their inclusion or exclusion can be found in Appendix 10.

I piloted the semi-structured interview protocol with two Ph.D. Counselling Psychology students who were not involved in the project. They assisted with timing, question editing, interview flow, and testing the recording technology. The final interview protocol can be found in Appendix 11.

Interview Participants & Sampling

Sixty out of 160 (38%) participants indicated an interest in the follow-up phone interviews. Fifty-one of the 60 (85%) read and agreed to the consent form (Appendix 4) and 46 provided a valid email address. All these participants were contacted 2-12 weeks after they completed the survey. Thirty-seven participants replied (80%), 36 of which were still interested in participating in the interview. I purposefully selected 11 participants who represented the survey sample on multiple demographic and response criteria including: ethnic/cultural background, age, gender, years of practice, practice location, practice setting, theoretical orientation, highest degree attained, and interest in the practice of SRA. Two of the 11 participants could not make their appointments and did not reschedule. Nine participants were interviewed. The emails sent to interview participants are detailed in Appendix 12. Table 3, Table 4, and Table 5 compare the survey and interview participant demographics. Table 6 lists each interview participant and their demographics.

Interview Collection

Prior to the interview, participants received a copy of their survey answers, and I told them they would be answering broad questions about their SRA practices, training, and experience. I said that there was no need to prepare anything, although they were welcome to review their attached survey responses. I also reminded participants about how we intended to anonymize the data and that they

should expect a synthesized member check request in the following month or two after their participation.

I completed interviews over the phone. I recorded the interview through a native phone application and an external audio recorder. I transcribed the audio first using Otter.ai (Liang & Fu, 2016) which is a speech-to-text transcription software that utilizes artificial intelligence and machine learning. I reviewed, anonymized, and edited the transcripts twice to ensure they were consistent with the audio before involving the co-investigator to do the same.

Interview Analysis

The co-investigator and I analyzed the data using one bottom-up approach (Inductive Thematic Analysis) and two top-down approaches (Deductive Thematic Analysis and Rapid Assessment Process). According to Braun and Clarke (2006), an inductive approach means strongly linking the themes to the data itself, whereas a deductive approach is driven by the analyst's desire to answer specific research questions.

In the first inductive approach, I began by familiarizing myself with the transcripts once more. At this stage, I had completed all the interviews and had reviewed each a minimum of three times, making notes at each pass. I inductively coded the transcripts using the methods described in Braun and Clarke (2006), including trying to interpret the data without analytic pre-conceptions. The co-investigator then reviewed each transcript without the codes, made notes, and reviewed them again with the codes. Together, we reviewed each transcript and their codes to ensure they were strongly linked to the participants' responses.

In the second step, we pivoted to a deductive approach, or Theoretical Thematic Analysis as referenced in Braun and Clarke (2006). Given the semi-structured interview protocol was designed such that each interview question answered an FURQ, I sectioned the transcript according to the FURQs and tagged the codes with their corresponding FURQ (see Appendix 10 to see how the interview questions

matched with the FURQs). I developed nine thematic maps for each FURQ and inductively generated themes. The co-investigator then reviewed the thematic maps and, having already been familiar with the codes, helped develop thematic descriptions. After iteratively discussing the resulting themes and corresponding codes, we noticed that the conceptual weight of the participants' answers was lost. Said differently, most participants provided a singular and succinct answer to our interview questions and then explained them in more detail; that singular answer was lost in this inductive/deductive analysis as the themes describing their direct answer had the same weight as the themes describing their explanations.

We rectified this problem in the third step using the Rapid Assessment Process (RAP; Beebe, 2001). RAP uses a deductive approach to focus the analysis directly on answering specific research questions. Given the purpose of this qualitative section is to directly explain some of the quantitative findings, we believe RAP is well suited for this study. We used and adapted the five steps listed by Hamilton (2013). First, I listed the FURQs and their corresponding interview question. Second, I created a summary template for myself and the co-investigator to use. We tested the summary template together on one FURQ and established a coherent analysis process. This process entailed reading the participant's answer to the interview question, and summarizing their answer in brief, summative bullet points. Third, we engaged in this summative process separately and across participants. Fourth we met to combine our summaries and aggregated our data across each FURQ, instead of across participants. Fifth, we independently developed themes that acted as direct answers to each FURQ. Lastly, we met again to collaboratively craft our final themes for each FURQ. Importantly, in this final process, the co-investigator and I reviewed our inductively generated codes and themes from earlier and incorporated missing elements into the descriptions. As there is no way to truly determine saturation, the co-investigator and I agreed that the current results answered the research questions with sufficient depth

and ended both the analysis and data collection (Braun & Clarke, 2019). An exemplar of this process is reviewed in Appendix 13.

Once we finalized the themes, we sent them for our participants to review as a synthesized member check (Birt et al., 2016). We provided a brief note on our analysis methodology and asked them to answer two questions: (a) do the themes match your experience? and (b) what would you change or add? The document sent to participants can be found in Appendix 14. Five of the nine participants responded with three providing feedback and the last two acknowledging that their experience was accurately reflected in the themes. The feedback was incorporated into the final themes presented in the results section.

We designed and iterated on this qualitative analytic process to promote quality and trustworthiness according to the principles identified in Morrow (2005). We aimed to be credible by using a consensus-based co-analysis, a synthesized member check, memoing, and providing "thick" descriptions of the themes that combine both the inductive and deductive analytic approaches. We inherently developed transferability by using an explanatory-sequential mixed methods design, as the qualitative interview results mapped directly to the generalizable quantitative survey results, and by writing researcher-as-instrument statements prior to data collection and analysis. We pushed for dependability by keeping thorough records of the analytic process through a research journal and detailing the chronology of our analytic process. Lastly, we actively promoted confirmability through this thorough discussion of trustworthiness and of our analytic process, and by including exemplars of said process in the appendices.

Integration

Integration in this project occurred at three junctions: (a) the development of the FURQs and the interview protocol, (b) the selection of the interview participants, and (c) the integration of the

survey and interview results. Whereas the former two have been elaborated in previous sections, this section will focus on the latter.

The process of integration answers my fourth, and final, research question: How do the interviews explain the survey results. To do this, I used joint displays (Guetterman, 2019; McCrudden et al., 2021), which are a visual, often table-based, representation of how the quantitative and qualitative results converge and diverge (Fetters, 2019). Specifically, I modified R. E. Johnson and colleagues' (2019) Pillar Integration Process (PIP) to better fit an explanatory sequential design, instead of the original convergent-focused design.

PIP has four stages: (a) listing, (b) matching, (c) checking, and (d) pillar-building. In listing, the researcher comprehensively or selectively lists the results from the quantitative (e.g., percentages, quotes) and the qualitative (e.g., themes) sections in the PIP template. We modified the template to showcase how our analysis was linear and explanatory instead of converging (see Appendix 15 for the template and our modification). We used our modified template to list all the quantitative findings and the qualitative themes as two columns. In matching, the researcher reviews the quantitative and qualitative data and finds commonalities among them, reorganizing the display so they match in a row. Matching, in this study, was baked into the design. As mentioned previously, the FURQs directly mapped onto the interview questions. And since the FURQs were developed by clustering interesting quantitative findings, we could directly trace most of the quantitative findings to the qualitative themes. Therefore, we matched the FURQs to the original research questions by examining what category of quantitative data was used to develop them. Most of these FURQs used data from only one section of the survey (e.g., 'How do psychologists choose their SRA practice' was developed just from survey answers in the 'Practices' section), with only a few having multiple section representation (e.g., 'How do psychologists understand the role of hospitalization in preventing suicide?' was developed from survey answers in the 'Practices' and 'Experiences' sections). We thereby, and simply, matched the FURQs to

the RQs based on what survey categories they best represented. Appendix 16 visually describes this logic and Table 7 details the RQ-FURQ match. In checking, the raw data is reviewed to ensure matches are appropriate and no data could be further matched. In this study, myself and the co-investigator reviewed the quantitative findings and the qualitative codes independently, then revisited our PIP table to ensure no meaningful insights were lost. Lastly, in pillar building, the researcher compares the findings in the joint display and develops insights that connect both data sets. Here, we wrote small thematic descriptions of our integrated findings, meant to be understood without having read the rest of the results. Said differently, we aimed to provide direct and digestible answers to the research questions.

Using guidelines from Onwuegbuzie and Poth (2016), six quality criteria are considered when completing, or evaluating, a quality MMR study: (a) persuasiveness of need, (b) clarity of influences, (c) transparency of designs, (d) rigor of implementation, (e) soundness of inferences, and (f) effectiveness of writing. Across all six criteria, elements unique to MMR include the justification of selecting MMR, the demonstration of a logical design, visual representation of integrated findings, and explicit use of MMR research questions. These criteria are consistent with other measures of MMR quality (Creswell & Plano Clark, 2018) which, in addition to MMR-specific rigor, calls for high research standards in both the quantitative (Creswell, 2015) and qualitative (Levitt et al., 2018; Morrow, 2005) strands. In explanatory sequential designs, Creswell and Plano Clark (2018) explain that careful attention should be given to (a) how the data strands were sequenced, (b) what factors from the quantitative results influenced the selection of the qualitative sample, and (c) how integration is represented through an explanatory joint display.

In the present study, these MMR quality assurances were met. Persuasiveness of need was met by a clear identification of the problem pursued and motivation for the problem in the Introduction Chapter. I also identified literature and methodological gaps, explained the purpose of MMR, wrote

MMR-specific research questions, and identified the study's significance. I met clarity of influences by making explicit my and the co-investigators' disciplinary and methodological backgrounds, described the context in which participants completed this study, and described their demographics. Regarding transparency of designs, I identified each point of integration, illustrated how each strand was integrated, and described each strand procedure in detail as well as their integration. We met rigor of implementation by describing our findings using a joint display and endeavored to meet the quality assurance standards for both data types. We met soundness of inferences by discussing the mixed insights, their limitations, and their future directions. Lastly, we met effectiveness of writing by explaining how MMR was incorporated throughout the project.

Researcher-as-Instrument

A fundamental part of qualitative research is researcher reflexivity and self-location (Braun & Clarke, 2014; Creswell & Plano Clark, 2018), and is becoming a growing part of quantitative research, too (Duffy & Chenail, 2009; Gelo & Carlo, 2012). This is equally important in MMR (Creswell & Plano Clark, 2018; Poth, 2018), although a recent review found only 8.7% of 322 MMR studies included any form of reflexivity (Cain et al., 2019). In this section, I reflect on my research worldview and my experiences with SRA.

Although I have completed studies under post-positivist (Dubue et al., 2015, 2018), constructivist (Dubue & Hanson, 2020; Gaine et al., 2021b), and critical realist (Gaine et al., 2021a) ontological and epistemological frameworks, I am predominately a pragmatist (R. B. Johnson & Onwuegbuzie, 2004). Pragmatism in research follows the maxim that meaning and truth of an expression is determined by the experiences or practical consequences of how the expression is realized in the world, which has been argued as the philosophical partner to MMR (R. B. Johnson & Onwuegbuzie, 2004). Said more pragmatically, Tashakkori & Teddlie (2010) argue that MMR binds "researchers" and "human problem solvers" together, where the human problem solver does not

discriminate between methodology, ontology, or epistemology when aiming to solve a problem, they simply use the best tools to solve the problem. They argue the process of conducting MMR is humanistic, where integration requires a human-focused methodological eclecticism. This eclecticism in pragmatism further lends itself well to collaborative and consensus-building analyses (Wachsmann et al., 2019), although it is articulated through the name dialectical pluralism (DP; R. B. Johnson, 2017). DP is a metaparadigm that describes the process of listening and processing multiple differences, such as worldviews and philosophies, to better honour the humanistic principles in MMR. Here, discussions (e.g., summarizing a FURQ, developing mixed insights) are fueled by a desire to find a better answer, not to prove a position. By these definitions, I am a pragmatist.

My experience of SRA is lengthy and opinionated. I began learning about psychotherapy at the Edmonton Distress Line, a 24/7 crisis line that, most of the time, was mired in risk assessments. At an impressionable 18 years of age, I became frustrated when my supervisors obliged that I complete all risk assessments as they arose in session, even if I and the caller felt they were irrelevant. A mention of suicide would entail a 10 to 15-minute information-gathering SRA, which, when compiled with other risk assessments, would take up most of the 20 minute-on-average call. My aversion to SRA was buffered by the belief that they kept clients safe, and that my assessments were reasonable, accurate, and helpful, even if clients protested. I often sacrificed connection in service of assessment, believing it was the most therapeutic. You may imagine my frustration when, after 5-6 years of practicing SRA, I learned SRAs do not predict actual risk of death, that risk factors contribute little to prediction, and hospitalization may cause more harm than good (Franklin et al., 2017; Large et al., 2011, 2016; Sommers-Flanagan & Shaw, 2017; Truscott, 2018). I began to question the clinical utility of SRAs and if psychologists knew that such an axiomatic practice may be outdated, let alone harmful. This inquiry inspired this dissertation, which was originally conceived as my master's thesis study. I hypothesized I would find representations of myself from the Distress Line in these data, where a majority would be practicing SRAs just like I was

taught ten years ago. Although my SRA experiences bias my understanding of the practice, I believe it critical to develop a neutral, actuarial understanding of how psychologists practice SRAs, how they are trained, and what they experience during SRA. In this neutrality, I can best understand the state of SRA in Canada, which will guide my SRA training development efforts and become the necessary steppingstone towards my career as a suicide prevention advocate.

However, a desire for neutrality is not sufficient to minimize analytic bias. Therefore, I recruited a co-investigator who wrote their own researcher-as-instrument statement (Appendix 17). We aimed to minimize bias by iteratively reviewing the data and using analytic processes that help us question our first interpretations (e.g., coding all written response in isolation, and then reuniting to build a final consensus). And, for more transparency, I have listed my original hypotheses which I developed prior to collecting data for this study: (a) psychologists, by-in-large, will be unaware of new developments in SRA research and practice, (b) most SRA practice will be based on information-gathering models that prioritize risk assessment over client connection, (c) psychologists will have received most of their training early in their graduate programs and during internship, although still report their training as insufficient, (d) fear of litigation will be a significant factor in determining how SRAs are conducted, including how psychologists react to SRAs, and (e) psychologists will report investing significant resources into their clients with suicidal ideation. These hypotheses were developed predominately from the results collected in my qualitative and exploratory master's thesis (Dubue & Hanson, 2020).

Chapter IV: Results

This chapter is divided into three sections: (a) Survey results, (b) Interview results, and (c) Integrated results. The survey results are organized according to the survey sections (Practices, Training, and Experiences) whereas the qualitative interview results are organized according to the follow-up research questions (FURQs) developed from the survey results (see Table 7 for a list of these research questions). The integrated results are divided according to the main three research questions: What are Psychologists' (a) Practices, (b) Training, and (c) Experiences of SRA in Canada.

Survey Results

Participants completed the survey between April and August 2021 (Figure 3) where the median completion time was 19.1 minutes. One hundred and forty-four (90.0%) participants completed the survey in English whereas 16 (10.0%) completed it in French. Most participants conducted an SRA in the last week (41.3%) or in the last month (31.3%) (Figure 4) and were "very interested" (48.1%) in the study and practice of SRA (Figure 5). Most participants heard about the survey through a Network or Organization (e.g., Societal/Regulatory Body) (46.9%), with the rest having heard through social media (18.1%), peer referrals (17.5%), or the Canadian Psychological Association's Research Portal (15.0%).

Practices

Participants frequently (38.1%) or almost always (23.8%) use SRA, with a majority (53.8%) assessing for suicide risk on first visits with new clients (Figure 6). On the long-answer SRA practices question (coding system is in Appendix 7), participants wrote between 6 and 1100 words with a median of 91.5 words. We coded 15.0% of these responses as "limited", 58.8% as "appropriate", and 26.3% as "thorough" (Figure 7). All responses were considered in the next analyses. 75.6% of psychologists conduct Structured SRAs, such that they ask specific questions in a specific order but do not use scales, measures, or other empirical systems. Comparatively, 17.5% of psychologists conduct Standardized SRA where they cite a scale, measure, or system, and the remaining 6.9% of psychologists use Fluid SRAs,

where their suicide inquiry is collaborative and determined by client responses (Figure 8). Most psychologists focus their SRAs on information-gathering (86.3%) whereas the rest prioritize the therapeutic opportunities in the SRA (13.8%) (Figure 9). The first step most psychologists take when responding to a suicidal client is assessment and information-gathering (56.3%), followed by connecting and being empathic (24.4%), exploring the suicidal disclosure (17.5%), and self-reflecting and self-regulating their current emotional and physical state (1.9%) (Figure 10).

Regarding specific practices (see Figure 11), nearly all psychologists asked about a suicide plan (95.0%) and most asked about risk factors (75.0%), suicidal thoughts (74.4%), and protective factors (63.1%). Most psychologists used these data to determine a risk level (65.0%) and develop a corresponding safety plan (67.5%), with a minority mentioning a follow-up (32.5%). In supporting suicidal clients, psychologists endorsed connecting them with external supports (62.5%), internal supports (44.4%), an emergency/24-hour contact (40.6%), and hospitalization (55.0%), with a very small proportion providing an out-of-session personal contact (4.4%). An increasingly smaller percentage of psychologists discussed the client's reasons for living (46.3%), about what is driving their suicidality (40.0%), the phenomenon of ambivalence in suicide (24.4%), and the limits of confidentiality (11.9%). Although 39.4% of psychologists used a humanistic skill, few engaged in hope-building (28.8%) and collaboration (17.5%). Only one participant asked about cultural or spiritual factors impacting the client's suicidality (0.6%) and at least 10% of psychologists continue to use no-suicide contracts (11.3%). For the participants who endorsed a specific SRA protocol (27.5%), we assumed they adhered completely to the cited system and coded their responses accordingly.

Training

Nearly all participants said they received SRA training (96.9%) and, when asked what kind of training they received, 98.1% endorsed at least one option. Participants endorsed a mean of 3.5 ± 0.14 (SE) training options with 13.1% endorsing only one option. Most psychologists received SRA training

outside of their graduate curricula either through professional development, workshop, or continuing education (71.9%) or self-directed or informal learning (58.8%) (Figure 12). Around half of psychologists received SRA training through their graduate program, either in their first or second year (49.4%), between their third and sixth (or more) year (42.5%), or in their full/part-time internship(s) (54.4%). Roughly a third of psychologists received SRA training in their volunteer or employed work (33.8%) or at a crisis center/distress line (30.6%). Lastly, a select few (6.3%) received SRA training in their post-doctoral year.

Regarding the kind of training received (Figure 13), participants reported that their early SRA training (first and second year) was predominantly instructional, whereas it became more supervisory-led in the later years (third to sixth year) and mostly supervisory-led in full/part-time internship(s). At the crisis center/distress line, psychologists noted their SRA training was equally instructional as it was active (e.g., role-plays) and that their volunteer or employed work training was mostly instructional. The post-doctoral year was mixed relatively evenly between academic, supervisory, active, and instructional kinds of training. When asked what kind of professional development (PD) participants completed, most psychologists (33.9%) reported having completed Applied Suicide Intervention Skills Training (ASIST; Gould et al., 2013), followed by training at a suicide-related community organization (22.3%), or a private workshop (14.3%) (Figure 14). Predominantly, psychologists who endorsed self-directed (SD) learning completed SRA-related readings (77.4%), followed distantly by self-guided learning of SRA protocols (20.4%) and consultation with peers and supervisors (19.4%) (Figure 15). Participants who completed the extracurricular professional development or self-directed training reported their motivation was due to seeing many high-risk clients (23.9% PD; 21.1% SD), increasing their own competence and skill (22.0% PD; 28.9% SD), or because of self-interest (21.1% PD; 28.9% SD). Psychologists' motivations did differ, as those who completed professional development were mostly required to do so by their work (40.4% PD; 5.6% SD), whereas those who completed self-directed

training endorsed their professional responsibility (10.1% PD; 23.3 SD), decreasing anxiety (5.5% PD; 12.2% SD), and staying up-to-date (4.6% PD; 15.6% SD) as motivation (Figure 16).

Out of all the available trainings endorsed, participants reported their most influential SRA trainings were professional development (32.5%), full/part-time internship(s) (18.8%), the crisis center/distress line (13.8%), and self-directed learning (13.1%) (Figure 17). Importantly, few psychologists endorsed their academic coursework and practica as their most influential training (8.8% total between first and sixth year). Psychologists received their most influential training mostly after graduate school (56.7%) and during graduate school (43.3%) (Figure 18). When asked what made their training influential, psychologists noted two main components: the training was experiential (32.9%) in that it had role-plays and active training, and that it was practicable (31.0%) in that it was easy to apply to their practice (Figure 19)

Most psychologists reported their graduate training prepared them to conduct SRAs (58.8% strongly agree/agree), although slightly below half said they received sufficient SRA training prior to seeing their first suicidal client (48.8% strongly agree/agree). Although psychologists are confident in their SRA practice (95.0% strongly agree/agree), most feel they need further training (53.1% strongly agree/agree) (Figure 20).

Experiences

Most psychologists' priority in conducting SRA is assessing risk (53.1%), whereas others prioritized safety (26.3%), and empathic connection (11.9%). 34.4% of participants wrote a second priority after the first, which predominately was safety (13.1%), treatment (7.5%), and empathic connection (5.0%) (Figure 21).

Just over half of psychologists believe the process of SRA helps them predict clients' risk of death by suicide (56.9% strongly agree/agree), and that they can rely on both clinical intuition (58.8% strongly agree/agree) and SRA scales (55.6% strongly agree/agree) to make these predictions (Figure

22). Most psychologists endorsed being knowledgeable (51.9%) or very knowledgeable (15.0%) of theories of suicide and suicide behaviour (Figure 23).

Few psychologists reported feeling stressed when asking if their client is thinking of suicide (18.8% strongly agree/agree), although this stress increases when conducting a details SRA (40.0% strongly agree/agree) with most feeling a sense of urgency when doing so (56.9%). Most psychologists find that treating a suicidal client is more stressful than treating other clients (77.5% strongly agree/agree), and that psychologists comparatively worry more about their suicidal client (72.5% strongly agree/agree). Although most psychologists put more effort into their suicidal clients (63.1% strongly agree/agree), only a minority offer extra or unique services to these clients (41.9% strongly agree/agree) and most have "never" broken their professional boundaries to prevent someone from dying by suicide (81.3%) (Figure 24 and Figure 25).

A large majority of psychologists believe conducting SRA helps prevent client deaths by suicide (87.5% strongly agree/agree) and that they know what to do when clients experience clear and imminent suicidal ideation (96.9% strongly agree/agree), with few fearing the involvement of third parties (e.g., emergency services, family member) (18.8% strongly agree/agree). Although a minority of psychologists feel powerless in preventing a client's death by suicide (16.9% strongly agree/agree), over half fear how they will cope if their client does die (56.9% strongly agree/agree) (Figure 26).

Although most fear how they will cope, an overwhelming majority know that losing a client to suicide does not mean they are a negligent psychologist (97.5%). Most psychologists, however, do believe it is their professional responsibility to prevent clients from dying by suicide (58.8% strongly agree/agree), that an improper SRA will lead to legal or professional issues if they do die by suicide (68.1% strongly agree/agree), and therefore use SRA to protect themselves from legal liability (66.9% strongly agree/agree). Despite these beliefs, psychologists feel like they know what the Code of Ethics (CPA, 2017) says about suicide prevention (80.0% strongly agree/agree) (Figure 27).

Under a third of participants reported having lost a client to suicide (26.9%). The median number of clients lost to suicide was 1, with a range from 1 to 20.

Interview Results

The nine interviews lasted between 18 and 41 minutes and were, on average, 28 minutes (SD = 7 minutes). Transcripts had between 2605 and 7192 words, with an average of 4282 words (SD = 1467). A summary of the interview results is in Table 8 and participant demographics, including their participant number, can be found in Table 6.

FURQ 1: How do Psychologists Choose Their SRA Practice?

SRA Practices are Haphazardly Chosen. Participants explained that they did not choose their SRA practice, rather they adopted practices from practicum and internship supervisors, developed their own from client feedback, embraced a workplace-specific practice, or formed one from post-graduate self-directed professional development. Participant 3 summarizes this sentiment: "…it's an integration of different training models, different observation, different workshops, different readings, and different practices, informed by my governing bodies, as well as my employer." This integrative process came passively, as participants noted how they "didn't choose it as much as it chose [them]" (Participant 1) and the eclectic mix of training makes it so SRA "[doesn't] feel like a distinct practice" (Participant 5). This is how most participants come to practice structured SRA, which Participant 6 explains: "I feel like I know what questions to ask and how to do the evaluation, but I don't use anything [specific]." Given SRA practices are indistinct, influenced by eclectic trainings, and "very little of it was teaching in classwork" (Participant 2), psychologists reflect that their SRA practices are informal and chosen passively.

FURQ 2: How and When do Psychologists Become Confident in their SRA Practice?

Confidence Comes from Practice with Feedback. Psychologists' confidence was developed through repeated practice with suicidal clients and by receiving feedback from supervisors, peers, and other interdisciplinary team members. Participants noted how when they "faced [suicide] almost every

day" (Participant 9) or "when [they] had to [assess suicide] more often with people at much higher risk" (Participant 8), their confidence grew. Others simply commented that confidence "comes with quite a lot of practice" (Participant 5), "endless practice" (Participant 2), or that they "had lots of practice [with suicidal clients] early on" (Participant 4). Others further noted that they became confident because they were "surrounded with mentors and peers in and outside their field" (Participant 8) and "worked in facilities with many professionals… [which] helped [them] to not feel alone" (Participant 9). A few participants noted they were wary of being overconfident, given that "human beings are unpredictable" (Participant 5), and that psychologists should "have a healthy degree of recognizing [their] limits, what [they] can't control, and that they may still make mistakes" (Participant 3).

Confidence Comes Years After Graduate School. All participants noted they were only confident after several years in independent psychotherapy practice. Several participants identified five years in practice was when they felt confident because they "feel as if [they're] capable of supervising someone else" (Participant 1) or they "[no longer] need to check in to make sure [they] did it right" (Participant 3). For others, confidence was developed "slowly over time" (Participant 8) and "with years" of practice (Participant 9).

FURQ 3: What Are Psychologists' Reasons for Using or Not Using SRA Scales or Measures?

Setting and Training First Determine SRA Scale Use. Participants identified their workplace or training first determined their SRA scale usage. When asked their reason for using or not using an SRA scale, Participant 9 said that "it was not really a choice; it was mandatory [to use an SRA scale] to work in the facility", which Participant 3 echoed, saying "this is where the employer comes in, because it was not necessarily my choice". Others commented their training better explained why they did or did not use SRA scales, which Participant 6 summarized: "It just wasn't something that was part of my training, so it didn't become part of my normal clinical practice." Participant 7 identified that using an SRA scale was an integral part of their Dialectical Behavioural Therapy training, whereas participant 2 noted how

they were never exposed to scales: "It wasn't a decision. None of my sites used a specific instrument… I didn't actually know they were a thing until recently". Importantly, all participants who used SRA scales said their decision came from training or their workplace and not from their own determination of best practices.

Standardized SRA Lacks Context and Harms the Therapeutic Alliance. The remaining participants did not use SRA scales because they believe it fails to gather important contextual information and harms the therapeutic alliance. Participant 1 illustrates the first half of this point with an example:

> This guy has a very close relationship with his mother, but his mother is experiencing a lot of medical health concerns. And he's very, very worried. I'm thinking, when she passes away, I think we should watch what's going to happen with him, because that's a huge support that's been pulled from him. Right? People need to be aware of that. Or you know, watch for August 25. That's the anniversary date this guy killed his father, and he had a loving relationship with his father. Watch him on that date. Those scales ain't gonna tell you that, but the qualitative information will.

Participant 8 furthers this argument in saying "what does [an SRA scale] tell you about their risk? Not very much unless I know the person, right?" Other participants discussed the impact SRA scale use has on the therapeutic alliance; Participant 5 said SRA scales "detracts from the conversation and… negatively affects the therapeutic space and relationship" and that "the second I take out my clipboard, it shifts the flow of the session". Participant 4 added, saying: "I work from a humanistic approach… [the SRA] has to become a normal part of the conversation rather than a 'let's fill out the form together'". Participant 5 summarizes how SRA scales harm the therapeutic alliance:

> …it gives the psychologist this fake sense of confidence that I checked off all the boxes, I did my job, and I scored you at low-medium because that's what the scale says… I think the scales are

> actually more about helping cover the ass of the psychologist than actually helping the client. I think that the research indicates that when the client feels seen and cared for, and important to the psychologist, that's what's actually important."

FURQ 4: How Do Psychologists Understand the Role of Hospitalization in Preventing Suicide?

Hospitalization Is a Last, Necessary Resort That Harms Clients. Psychologists understand hospitalization as a last resort, used only when all other safety options have been exhausted. Participant 7 said: "I will only hospitalize a suicidal client if they can't meaningfully commit to staying safe for even 24 hours", which Participant 2 reiterated, saying "I do try to maintain safety in the home; that's always going to be my first preference". Participant 3 continued this point, saying: "I actually have a high tolerance for not hospitalizing and really try to work on alternatives." This tolerance is present in part because psychologists also see hospitalization as harmful to their clients. Participant 5 recalls:

> I don't have a single client, I literally don't have one client, who has told me that [hospitalization] benefited them. They've all told me that they left feeling more harmed and more damaged. I've had clients say: 'I want to kill myself. I then go to the unit, and I want to kill myself more. It's a horrible place to be. They dehumanize me, and I feel even worse about myself. And, sure, I don't die, but I'm wishing that I was dead even more than I was before I went to the unit…' [The psychologist] did more harm than good and they're not going to trust the next psychologist that they come in contact with."

Other participants reaffirmed this sentiment; Participant 2 said their clients "often find the experience of going to the hospital to be horrible" and Participant 3 said that "hospitalizations were sort of 72 hour holds and were not all that therapeutic." Despite this, psychologists believe it better to harm the client in service of keeping them alive. Participant 3 explains: "however bad the decision, I'd rather [the client] be alive to have that [bad hospitalization] experience. And then, you know, they can yell at me after about it."

FURQ 5: How and When Do Psychologists Believe They Should Be Trained in Suicide Prevention?

Psychologists Are Not Ready for SRA Practice During Graduate Training. Seven of the nine participants indicated they were ready to work with suicidal clients only after their graduate training. Psychologists said they "never felt ready" (Participant 2), with most feeling ready "only after graduate training" (Participant 9). Some identified that the dearth of SRA training was the culprit: "prior to [the end of graduate training], I don't think I received anything more than maybe just like being told to read an article or something about it." (Participant 7). Because "[SRA training] wasn't in the curriculum for the program" (Participant 1), many got their SRA education "on the job" (Participant 2) or had to "lean heavily on [their] supervisor's expertise" (Participant 3). The rest of the participants detailed how in-vivo supervision and experiential training helped them feel ready, earlier.

Psychologists' Best SRA Training Is Supervised Experiential Practice. In describing their preparedness, nearly all psychologists highlighted how they learned suicide assessment and prevention from their practicum or internship supervisors. Participants repeatedly said: "I have some excellent supervisors" (Participant 2), "when I think back over all my experiences, I always had a good supervisor" (Participant 4), and "the ease of access to my supervisor… was important in my training." (Participant 8). Others noted how the training was most helpful when it was "in action" (Participant 9) with "live observation" (Participant 4) and role-plays, often concurrent with supervision during practica and internship. One participant did not receive, and yearned to have, this kind of supervised experiential training: "We should have done more role-plays, more scenarios… We did that with other clinical situations, but we didn't do that with suicide" (Participant 3). Receiving in-vivo feedback (peer and supervisor) and experiential practice (e.g., role-plays) were important in getting them ready to see suicidal clients.

Suicide Assessment and Prevention Is a Core Competency That Should Be Mandatory Learning in Graduate School. Participants further elaborated that their graduate training seldom included

intentional suicide assessment or prevention training, despite it being a critical feature in psychologists' practice. Many participants "didn't get formalized training" (Participant 5) and if they did, they "didn't really dig into it in class" (Participant 2). Given that "every single psychologist… is going to address suicide" (Participant 5), several participants advocated for the inclusion of "mandatory or formal training" (Participant 6) that is "incorporated in the curriculum on models of therapy… or even its own class" (Participant 7). Participant 2 reinforced this argument:

> People are horrifically under trained. And a lot of people end up like me with this, like piecemeal training on it… And I think when we don't make it a core part of our training, it gets avoided because it's scary. It is very anxiety inducing for lots of clinicians. We are not magically exempt from avoidance… I think it must be required, and it should be a core competency. Even clinicians like me, who are really interested in it, I feel like I didn't get anywhere near enough training.

Given that suicide assessment and management "is a core skill" (Participant 2) that "everybody's going to have to do at some point in their career" (Participant 7), psychologists here argued for graduate training include dedicated coursework prior or during practica.

FURQ 6: How Do Psychologists Understand the Etiology of Suicide?

Suicidality Is the Hopeless Belief That the Pain Will Never End. Participants understood ambivalence and hopelessness as the main etiology of suicide. Participants frequently noted that suicide is not "…a desire for death. It's really an escape from pain… Stopping that [pain] is what they truly crave. And it's the hopelessness, that it will or that it can [stop]." (Participant 8). Importantly, participants noted that chronic suicidality was marked by the belief that clients "experienced such prolonged suffering with no improvement, that death becomes better than continuing with the suffering." (Participant 5). Others qualified more features of suicidality such as "lacking purpose" (Participant 1), a way of "communicating something to the environment" (Participant 7), and that "it's a coping

mechanism, like avoidance [of pain]" (Participant 3). Further, some participants emphasized emotional regulation, which Participant 7 explains:

> People become suicidal because there is an overwhelming emotion that they don't know how to regulate. And the solution that their brain generates is that it would be better to be dead than to experience this emotion because they believe they will experience it forever.

Ultimately, psychologists here noted that suicidal clients often feel stuck, "lack purpose" (Participant 1), and "lack important human relationships" (Participant 5). Suicidality, according to psychologists, is a symptom of distress.

FURQ 7: What Makes Working with Suicidal Clients Stressful to Psychologists?

The Conflict of Being Responsible and Caring. For most psychologists, it is the inability to guarantee their client's physical safety that makes working with suicidality stressful. Participant 3 elucidates: "I want people to survive… And so, I feel like I have that added responsibility to really ensure that something impulsive doesn't happen, or something they might regret." Even though most participants "are trying to help them, care about them, feel responsible for them" (Participant 6), a majority knew that "at the end of the day, they can't make somebody be safe… if somebody really wants to kill themselves, they will." (Participant 2). The inability to guarantee their safety while still feeling responsible is what Participant 3 identifies as an ethical stressor: "that adds that stress… you're doing all the ethical and legal decisions and… it's too much." The same participant also notices this stress pushes them to become paternalistic: "I feel that sense of protection kicks up, even though I really am trying to empower people to make their own decisions. I do feel like there's a little bit of paternalism that kicks in, which is counter to a lot of my therapeutic approaches." (Participant 3). Others noted that suicidal clients require more administrative resources and emotional labour:

> Often when clients are suicidal, they're in distress. Maybe they're crying more in the session, or they feel more hopeless in the session. And I think that kind of that energy can impact me as

> well. It takes a lot of work to kind of sit with the heaviness of that… I have to take some intentional work to set some boundaries" (Participant 4)

Others feel stressed because it increases their workload; Participant 5 said "I'm reaching out to the client, I'm phoning them, and I'm increasing my sessions." whereas participant 7 said "you might make four or five phone calls that you're not paid for." Participant 3, who was less stressed about suicidal clients, identifies how resources at the hospital allows him this comfort:

> I couldn't do my job and feel good about all my assessments if I didn't have the infrastructure in place at that hospital. I had a 24/7 psychiatry hotline, we had a 99-bed inpatient unit, we had day hospitals, we had the bridge unit, we had somebody on call for psychology 24/7, so I could function and thrive. I couldn't be successful without all that infrastructure, allowing me to focus on the clinical interview. I think that is what a lot of people struggle with; if you ask and they're suicidal, and you don't have resources to deal with it, then you're sunk and you're stuck.

Importantly, nearly every participant noted how perceived risk directly impacts their stress. For some, low-risk clients are "just the same as others" (Participant 1) as psychologists "have lots of clients who have thoughts of suicide, and [they] would not categorize them as suicidal. It's the high-risk people who [they are] really worried about." (Participant 5).

FURQ 8: How Do Psychologists Understand Their Ethical Responsibility Regarding Suicide Prevention?

Assess To Minimize Harm, but Seldom To Maximize Benefit. Most psychologists answered this question saying it is their "ethical responsibility to do the best assessment [they] can." (Participant 2) Participants reiterated that it was "ethical to explore it…not dismiss it" (Participant 3), to have "done a really thorough assessment… and keep them safe" (Participant 6), "assess the level of risk" (Participant 7), or simply "to do that assessment" (Participant 8). The focus on assessment often was to "maintain [client] safety" (Participant 2), as the outcome of their safety "became the priority… because [they were] so worried about liability" (Participant 4). A few mentioned the importance of balancing safety and

privacy, which Participant 6 summarizes: "I feel ethically responsible to keep them safe but protect their privacy at the same time... that's always a huge balance." A few participants noted how their responsibility was not necessarily to keep their client safe, nor practice with litigation in mind, but rather to "discuss [suicide] as thoroughly as [they] would discuss anything else." (Participant 5). These participants noted that being "worried about liability… came at the expense of having dignity for the person" (Participant 4). This same participant continued:

> And with that pressure off… [without] feeling like: "Oh no, I'm going to be liable for this. Am I going to get sued?" that I can actually do a better job and be present with clients. And that reduces the client's distress and helps them to be, hopefully, less suicidal. Of course, it's important to be thinking about practicing ethically, but… I think if we're guiding our decisions based on that fear, I don't know if we're doing our best work as therapists.

Another participant noted that their fear is centered around intervention rather than prediction: "My worry about litigation is not whether or not the client has committed suicide. My worry about litigation is 'I didn't follow up and have a meaningful discussion or intervention with them.'" (Participant 1). Participant 5 continued, arguing that attending to the client's needs is what is most ethical:

> I think that the research indicates that when the client feels seen and cared for, and important to the psychologist, that that's actually really important… If a psychologist says I'll hear your story, you can tell me all of it, like that doesn't frighten me. Like if we see them authentically in their full self– I wouldn't even call it a risk assessment, having conversations about thoughts of suicide or suicide attempts. Like that's where I think we affect change for people.

Despite this, all participants noted, in some way, "[they] know it's not for real that [they] are responsible, but it's hard to not feel responsible." (Participant 9).

Integrated Results

In the integration phase, we answer the final research question "how do the interview results explain the survey results?" and is divided according to the first three research questions: (a) What are psychologists' practices of SRA, (b) How are psychologists trained in SRA, and (c) How do psychologists experience SRA? For a review on how the quantitative findings were matched to the qualitative ones, please see Appendix 10, Appendix 16, and Table 7. A summary of these integrated results can be found in Table 9.

What Are Psychologists' Practices of SRA?

Most psychologists use structured SRAs (76%), such that each psychologist has an idiosyncratic organized set of assessment questions and processes that loosely resemble each other. Interview participants explained that they came to this practice haphazardly, passively adopting the SRA practice of their practicum or internship supervisor(s) or aggregating the training they received from, on average, 3.5 training locations. Only 28% of psychologists use a specific SRA protocol, scale, or measure in their SRA practice, despite a majority (56%) trusting them to determine suicide risk. Interview participants who used said protocols did so because they were either explicitly trained to do so (e.g., like Dialectical-Behaviour Therapy uses the L-RAMP) or because their work required them. The remaining 72% did not use an SRA protocol, which interviewed psychologists explained is because they believe SRA protocols fail to contextualize their client's distress, miss key risk data, and ultimately harm the therapeutic alliance. Importantly, the decision to use or not use an SRA protocol is unrelated to predicting suicide risk, as a comparable 59% of psychologists also rely on their clinical intuition to determine suicide risk. Psychologists' selection of an SRA practice lacks a fundamental feature of the scientist-practitioner model, in that there is little intention in their choice and too light a review of the effectiveness of their SRA practice.

Nearly all (95%) of psychologists were confident in their SRA practice, a process that took some five years or longer. Becoming confident in SRA meant repeated practice with feedback from peers,

supervisors, and other mental health team members. Although 58.8% of psychologists believed their graduate training prepared them to conduct SRA, interview participants qualified that being prepared and confident are separate phenomena, with the latter being achieved around the time a psychologist is deemed competent to supervise their own supervisee.

Psychologists consistently noted how hospitalization is a harmful, therapy alliance-breaking tool that is used as a last and seemingly necessary resort to prevent physical harm. Despite this belief, 81% of survey participants did not fear involving third parties when their client was imminently suicidal, and 97% reported knowing how to conduct said referral. Interview participants explained this lack of fear comes from the assurance that the client's physical safety is maintained, and that they are confident they can handle the consequential harms to the therapeutic relationship.

How Are Psychologists Trained in SRA?

Interviewed psychologists resoundingly reported receiving lackluster and insufficient SRA training in graduate school. Considering that suicide assessment and management is an inevitable practice, it is striking that 41% of psychologists do not believe their graduate training prepared them sufficiently and 51% did not receive enough training prior to seeing their first suicidal client. Those who endorsed sufficient graduate training or felt ready to see suicidal clients early in their training, explained they received experiential (e.g., role-plays and direct suicidal client contact), supervised, and practicable training, typically from their practicum supervisor. These participants also identified how graduate SRA training is inconsistent, insufficient, and largely made the responsibility of their practicum supervisors. This highlights a deficit of graduate training programs, as 71% of survey participants also endorsed getting their most influential training outside the graduate curriculum, with 57% completing it after graduating. Interviewed psychologists widely supported more dedicated suicide assessment and management coursework in their graduate training that deemphasized practicum supervisors as the main teachers of SRA.

How Do Psychologists Experience SRA?

Most interviewed psychologists understood suicidality as the hopeless belief that pain will never end, yet only 40% ask about the pain in their SRA. Despite this etiological understanding, 88% agree that SRAs, which mainly focus on risk assessment and information-gathering, help prevent client deaths by suicide. Some interview participants reconciled this difference by suggesting suicidality is more about unregulated emotions or cognitive distortions, which are presumably treated outside the assessment. Others noted their SRAs intentionally involve the client, as a therapeutic and fluid process, to help the client recognize their pain as the driver to their suicidality. However, 57% still agree that SRAs help predict client death by suicide and 57% also begin their SRAs by asking a risk-related question. Psychologists' experience of SRA here is conflictual; psychologists know suicide is due to excruciating emotional pain, but seldom take the next step to assess or develop a treatment plan to address the client's anguish.

Feeling conflicted is a salient feature of treating a suicidal client, as interviewed psychologists identified the common tension of being responsible for their clients' safety while caring for their emotional well-being. Interview participants explained this is why 73% worry more about their suicidal clients and 78% are more stressed during their treatment, which is proportional to their perceived risk level; the higher the risk, the higher the stress. However, the process of conducting an SRA is not too stressful, as only 19% feel stressed when asking if their client is thinking of suicide. This stress increases as psychologists dig deeper, with 40% feeling stressed when conducting a detailed SRA. Interviewed psychologists explained this added stress comes from needing to invest more administrative resources and emotional labour in the client; relatedly, 63% of psychologists put more effort in their suicidal clients and 42% offer services not typically offered to non-suicidal clients. That said, 81% said they never broke professional boundaries to prevent a client's death by suicide, which interviewed participants

reiterated and acknowledged the importance of creating clear boundaries to protect themselves legally and emotionally.

Despite these boundaries, the fear of legal ramifications remains high in psychologists. Most (68%) fear an improper SRA will lead to legal or professional issues if their client dies by suicide and consequently, 67% use SRAs to protect themselves from legal liability. Most interviewed psychologists believed that the SRA is an ethical requirement, and that being thorough is equally important. Some of the interviewed psychologists noted how this thought process was focused uniquely on minimizing client harm, rather than balancing it with maximizing benefit. Despite 80% of psychologists believing they know what the Code of Ethics says about suicide prevention, most fear losing a client a client to suicide, due to a perceived ethico-legal liability. Some interviewed psychologists noted their ethical responsibility to balance assessment and treatment, although only two identified their biggest fear was not giving the client appropriate treatment for their suicidality. The experience of SRA for psychologists is stressful, as they navigate perceived ethical and etiological conflicts while disproportionally expending professional and personal resources.

Chapter V: Discussion

The purpose of this study was to explore and explain how psychologists practice, learn, and experience the process of conducting suicide risk assessments in Canada. Using a sequential mixed method design, we surveyed 160 psychologists and followed up with nine of them for in-depth qualitative interviews. Integrating both methods, our results answered the research questions: (a) How do psychologists practice SRA, (b) how are psychologists trained in SRA, and (c) how do psychologists experience SRA, which were augmentatively explained through our last research question, (d) how do the interviews explain the survey results. Together, we measured the pulse of psychologists' SRAs in Canada and, in this section, contextualize these vital signs across other literature.

This section begins with a discussion of the seven integrated findings (Table 9): (a) SRA practices are idiographic and haphazardly chosen, (b) psychologists take years to become confident in SRA, (c) hospitalization is a harmful last resort, (d) SRA training can be improved through experiential and practicable pedagogy, (e) psychologists see suicide as a symptom of a psychosocial issue but do not focus on its treatment, (f) treating a suicidal client requires more administrative and emotional resources, and (g) psychologists practice fear-based SRA. Afterwards, I review the study's (h) limitations, and (i) methodological contributions, propose (j) future directions, describe some (k) implications for practice, training, and policy, and end with a (l) conclusion.

SRA Practices are Idiosyncratic and Haphazardly Chosen

We found that most psychologists' SRA practices begin with and emphasize gathering risk-related information, often through a semi-structured interview that is well-practiced and idiosyncratic. That is, most psychologists asked very similar questions to one another, but used different language and asked them in a different order, making most responses unique yet consistent. Nearly all psychologists asked about their clients' suicide plan, and three-quarters asked about risk factors or the presence of suicidal thoughts, with less than a fifth of psychologists asking these questions through standardized

measures or protocols. The interviewed participants explained the divergence in these SRA practices is due to the equally disorganized SRA training, which is often taught as a collection of practices without a guiding pedagogy or empirical framework. Without a system or standardized approach to teaching SRA, most psychologists end up with SRA practices that are a hodgepodge amalgam of their training experiences, the most influential version often coming from their practicum or internship supervisor.

The SRA practices recorded in this study are, by in large, consistent with other research. Firstly, Rothes and Henriques (2018) found 39% of their sample used formal instruments to assess for suicide, compared to this samples' 28%. They also found that 37% use specific behaviour assessment instruments and 46% use specific intervention protocols, suggesting that their sample uses more standardized means of assessing and treating suicide. This remains somewhat true even when broken down to the question; three quarters of my sample assessed for risk factors, whereas Rothes and Henriques's (2018) sample had 88% assess for risk factors, 84% asked about prior attempts, 73% asked about underlying loss, and 66% asked about family suicide background. In Rozek and colleagues' (2022) study, between 48% and 85% used a crisis response or safety plan, which is consistent with the 68% that endorsed safety planning in my sample. Regarding contraindicated or inconclusive practices, about 10% of my sample cited using no-suicide contracts, compared to Rothes and Henriques' (2018) 36%, Rozek and colleagues' (2022) 14-36%, and Bruno's (1995), who found psychologists rated the frequency of evaluating the appropriateness of a no-suicide contract as 5 out of 7 (7 = always). As well, about half of my sample almost always used SRAs on first visits, which is consistent with Erps and colleagues (2020) finding that half of their school psychologists believed suicide should be universally-screened.

These results suggest that my open-ended SRA practices question provided comparable results to other studies examining SRA practices through checklists and scales, with one notable difference. In my study, only 40% wrote about how they acknowledge or assess the drivers to their client's suicide, compared to the 91-94% of participants in Rothes and Henriques' (2018) study who ask about what led

their client to suicidal ideation or attempts. This is a large difference that, on the surface, suggests that fewer psychologists in my study try to understand their clients' motives to suicide than other literature. However, given Rothes and Henriques (2018) used a checklist, I suggest this difference is an authentic reflection of psychologists' priorities; over 75% of my sample prioritized assessing risk and safety in their SRA, which is consistent with what they included in their long-answer response. I am not contending psychologists do not assess or try to understand the psychosocial drivers to their clients' suicide, rather, they seem to do so in the background. This is a crucial difference, as driver-focused and collaborative SRAs make the assessment of suicide motivations intentional and vocal, giving the client an opportunity to co-define these drivers.

Although no other study has examined how psychologists chose their SRA practice, comparing my results to other findings offers augmentative insights, particularly regarding (a) the influence of psychologists' practice setting, (b) exposure to SRA scales, and of the (c) therapeutic alliance. Interviewed psychologists in my sample noted that working in hospitals and public health settings typically meant abiding by a centralized authority which mandated SRA scales or protocols, where there was very little, if any, choice about their SRA practice. This may explain why Rothes and Henriques' (2018) sample, which primarily worked in tertiary care settings, practiced more standardized SRA. Participants in my study also noted that deciding how to practice SRA was also based on whether they were exposed to standardized scales in their SRA training. Liebling-Boccio and Jennings (2013) found that just above half of psychologists are trained in SRA scale (54%) use, which is significantly higher than the 17% of my sample that currently use them. This may suggest that exposure to SRA scales is not a significant deciding factor, a conclusion that would be consistent with my other qualitative finding explaining how psychologists reported avoiding SRA scales because they believed they harmed the therapeutic alliance. Overall, these data support the conclusion that psychologists passively chose their SRA practices, with most of the influence coming from their setting or training.

Psychologists Take Years to become Confident in SRA

Nearly all psychologists in my study reported they were confident in their SRA practice, a process that interviewed participants qualified as taking around five years post-graduation and was largely achieved due to supervised experiential practice. This result is, to my knowledge, the first to describe graduated psychologists' confidence in SRA, whereas previous research examined students, interns, and graduate training directors. Combined, these results add to the literature by explaining past findings and further detailing the SRA training-to-practice pipeline.

One of the first studies on SRA confidence came from Dexter-Mazza and Freeman (2003), who found psychology interns all had a high level of confidence and felt knowledgeable about suicide, despite half having never received formal SRA training. This was a surprising finding, as the authors expected those with more formal SRA training would have higher confidence. My results help explain this apparent discrepancy, considering the fundamental impact of experiential training on practitioner's confidence. The interns in Dexter-Mazza and Freeman's (2003) study were likely all receiving some degree of supervised experiential practice, which psychologists in my study explained was where they started to genuinely develop their confidence. Said differently, formal didactic SRA training is not likely to have an impact on practitioner confidence. This explanation is also consistent with Kleespies and colleagues' (1993) findings that students in graduate psychology programs report low confidence in light of very little SRA training, as we should not expect students, who have not yet practiced SRA in an experiential way, to be confident in their SRA practice. This is also the case with Kerr's (2019) sample of internship-ready students who achieved an advanced level of SRA skill while self-rating themselves as competent, demonstrating a high, yet appropriate, level of confidence.

Despite this high level of confidence, half of my sample agreed they need further training in SRA which is consistent with Kerr's (2019) finding that 66% of doctoral psychology students desired more training. This is unsurprising, as many studies review and acknowledge the dearth of formal SRA training

in graduate studies (Bongar & Harmatz, 1991; Dexter-Mazza & Freeman, 2003; Dubue & Hanson, 2020; Kerr, 2019; Liebling-Boccio & Jennings, 2013). Yet, Kerr (2019) demonstrates internship-ready students are competent, which begs the question, why should we improve this training if our systems are presumably achieving their goal? Firstly, my study, and Dexter-Mazza and Freeman's (2003), demonstrate that only half of the sample felt they received sufficient SRA training prior to seeing their first client. This is problematic; suicidal clients who are accessing student clinics should not have the odds of a coin toss in seeing a clinician who feels they are ready to help them deal with what are likely their darkest thoughts. Secondly, dedicated coursework in SRA does increase clinicians' confidence, as reported in Sawyer and colleagues' (2013) pre-post survey of master's students who completed a crisis intervention course. We can, indeed, cultivate appropriate confidence through more robust graduate SRA training, provided it is offered earlier in a clinician's training. Thirdly, confidence is a significant factor in increasing a clinician's motivation to practice SRA (Monahan & Karver, 2021). Early experiential training under supervision motivates clinicians to practice more SRA, which activates the feedback loop of increasing their confidence. It is parsimonious to suggest that suicidal clients are more likely to feel comfortable sharing their suicidal thoughts with clinicians who are confident they know how to assess and manage said suicidality. And finally, 92% of training directors believe it is the responsibility of graduate institutions to instruct students in SRA, with 73% believing they should be confident after receiving this instruction (Liebling-Boccio & Jennings, 2013). Together, these results highlight the demand, supply, and responsibility for better and earlier formal SRA training.

Hospitalization is a Harmful Last Resort

Slightly more than half of my sample mentioned or considered hospitalization when discussing how they would assess and manage a client's suicidality, which is lower than the 71% of mental health clinicians who endorsed the intervention in Rozek and colleagues' (2022) study. Other research studies report a much lower endorsement; only 14% of psychologists endorsed hospitalization in Rothes and

Henriques' (2018) study and only 7% of school psychologists recommended hospitalization for the high-risk vignette in Gerardi's (2018) study. Evidently, psychologists have a large variance in their likelihood of endorsing or recommending hospitalization. One particular reason may be exposure to the practice, which is limited. Liebling-Boccio and Jennings (2013) reported that training directors believe only 9% of their students are fully prepared to facilitate hospitalization, 4% are fully prepared to reintegrate their client after hospitalization, and 6-7% are fully prepared to engage in postvention interventions; these activities are what training directors believe students are least prepared to practice in SRA. Similarly, Rothes and Henriques (2018) compared psychologists to practitioners who almost always work in hospital or medicalized settings, finding both psychiatrists (40%) and general practitioners (43%) were much more likely to endorse hospitalization compared to their psychologist peers.

The results of my study reveal another reason; practitioners may avoid endorsing hospitalization because it risks harming the client. As reviewed in the introduction, inpatient hospitalization risks iatrogenic harm by compromising the client's autonomy and sowing distrust in the therapeutic alliance (Aboussouan et al., 2022; Hom et al., 2019; Jones et al., 2021; McKernan et al., 2018). However, these harms were insufficient in the eyes of the interviewed psychologists who identified they would hospitalize their client if it meant keeping them physically safe. Even participants who thoroughly discussed the harms hospitalization had on their clients endorsed the practice in the event of imminent and clear harm to self.

Importantly, hospitalization is not a contraindicated practice according to popular and recent practice guidelines (American Psychiatric Association, 2003; National Action Alliance for Suicide Prevention, 2019) and it is taught as an effective and recommended practice in ASIST, psychologists' most popular professional development training (Ashwood et al., 2015; T. Davis, 2019). In other training programs focusing on the treatment of chronic suicidality (e.g., Skills for Safer Living; Bergmans, 2017), hospitalization is still recommended, but nuanced with a collaborative decision-making process. The

recommendation is that practitioners prepare their clients for hospitalization, noting the risks and benefits, and framing the experience as a temporary restraint to maintain their safety. This can manifest in an emergency department letter, which details why the client is presenting to the hospital, what they are expecting to receive as a service, and what conditions need to be met for a collaborative discharge. Although evidence in support of these practices is anecdotal, they are in line with the changing zeitgeist of suicide management; they are collaborative, autonomy-promoting, and client-centered.

The results of my study further highlight that psychologists feel they know what to do and do not fear involving third parties when a client presents with imminent and serious harm to self. Even though they may not fear the practice of breaking confidentiality, psychologists reported this was an absolute last resort, with some of them identifying hospitalization as an irrevocably harmful practice. As a result, clinicians feel uncertain and worry when deciding to hospitalize a client, which is what SRA tools and risk formulations were meant to reduce through standardization (Regehr et al., 2022a). This process is also worsened by the fact that, over the last 50 years in Canada, community mental health resources limitations has inadvertently increased involuntary hospital admissions sixfold (Lebenbaum et al., 2018). With this continued strain on emergency resources, it may be helpful to teach psychologists how to minimize the harms of hospitalization and increase their risk tolerance to avoid sending them to an overwhelmed emergency system.

SRA Training Can Be Improved Through Experiential and Practicable Pedagogy

A recurrent discourse across the literature and my experiences of SRA is the lack of quality graduate-level training. Despite 92% of training directors believing it is their programs' responsibility to instruct students fully in SRA, 41% of my participants and 63% of Erps and colleagues' (2020) believe their graduate training did not prepare them to conduct SRA. Relatedly, 53% of my sample and 66% of Kerr's (2019) believe that they need more SRA training. Two potential reasons this may be occurring is

because SRA training: (a) is not happening during graduate studies, and (b) is being taught using less effective pedagogies.

A consistent finding across SRA training literature is that psychologists are not receiving SRA training during graduate studies. In my study, less than half received formal graduate-level SRA training, not including internship, with many receiving their most influential SRA training after graduate school, typically in external professional development settings. There is a large variance of comparable results across the literature; 69% (Bruno, 1995), 18% (Rothes & Henriques, 2018), and 46% (Erps et al., 2020) of psychologists and 80% (Mackelprang et al., 2014) and 78% (Kerr, 2019) of psychology trainees reported receiving graduate-level SRA training, with 39% (Bongar & Harmatz, 1991) and 51% of training programs reportedly offering formal SRA training (Dexter-Mazza & Freeman, 2003). As well, Monahan and Karver (2021) found that participants reported an average of 11 hours of graduate SRA training, compared to half of Liebling-Boccio and Jennings' (2013) sample reporting 5-6 hours. These results indicate that there is likely more SRA training being provided at the graduate level today, as more recent studies endorse a higher frequency and amount of time spent learning SRA, with trainees reporting more involvement in SRA than actively practicing psychologists. Despite these increases, it does not excuse how half of graduate programs did not offer any SRA training (Dexter-Mazza & Freeman, 2003). The lack of graduate training inadvertently pushes trainees and graduated psychologists to seek training elsewhere, such as the 72% in my study or the 76% (Brown et al., 2017), 68% (Gerardi, 2018), 78% (Erps et al., 2020), and 79% (Chu et al., 2017) of psychologists in other studies who received post-graduate professional development, or the 59% of trainees who found external training (Kerr, 2019). Most of the participants in my study cited professional development as their most influential training and that they had received it after they graduated. Considering 97% of psychologists encounter a suicidal client before completing their formal training (Kleespies et al., 1993) and that training directors feel responsible for providing SRA

training, it is crucial that suicide prevention and crisis management become a core part of psychologists' training curriculum.

The second reason psychologists lament their SRA training is that, even if it is present, less effective pedagogical approaches are often used. Participants in my study elaborated that what made their most influential training influential was because it was experiential and practicable, that is, practiced in class (e.g., role-play) and feasibly integrated into their work with clients. In contrast, they identified their graduate training was mostly instructional and academic, with active/experiential learning being the least endorsed. This is consistent with other research; 53% (Gerardi, 2018), 76% (Mackelprang et al., 2014), 55% (Kleespies et al., 1993) and 23-27% (Bongar & Harmatz, 1991) of psychologists and trainees reported their SRA training was didactic lectures, which is consistent with 94% of SRA training being provided through lectures, and 89% through assignments, and only half (54%) being experiential (Liebling-Boccio & Jennings, 2013). This didactic-focused pedagogy is well endorsed across training programs (Dexter-Mazza & Freeman, 2003).

Binkley and Elliott (2021) identified this same pedagogical issue and examined exactly how SRA is taught in counsellor's graduate training. They found three reasons why SRA training has not become better: (a) lack of training guidelines and standards, (b) little research on pedagogy, and (c) few actual measures of trainee's competency. They first discuss how the most recent training standards of the counselling professions' main accrediting body, the Council for the Accreditation of Counseling and Related Educational Program (CACREP), only mentions suicide prevention models twice, without any discussion of treatment or management of suicidal behaviour. This is consistent with psychologists' standards, too; in the most recent revisions of the CPA's accreditation standards for doctoral and residency programs in professional psychology, there is no mention of suicide, crisis, or risk, nor are they explicitly discussed under any of the fundamental competencies (CPA, 2021). A second issue identified by Binkley and Elliott (2021) is how little research we have regarding crisis-related pedagogy. In one such

study, the authors described how teaching SRA through experiential approaches could decrease trainee's anxiety by helping them better experience and transform their learning into practicable and personalized practice (Miller et al., 2013). However, without further research, the best evidence we have in support of experiential approaches is theoretical, albeit routinely endorsed and welcomed by trainees and psychologists. Lastly, Binkley and Elliot (2021) identified a lack of studies examining clinician's competency in SRA, with accreditation standards and training directors providing vague references to the assessment of such competency, relying heavily on self-reported student self-efficacy. This is important, as competence appears to influence the likelihood a practitioner will even see a suicidal client (Groth & Boccio, 2019; Rothes et al., 2014). They conclude by suggesting we have a robust understanding of what information clinicians should know, but very little understanding of how they should come to know it.

The last point made by Binkley and Elliott (2021), that there are few measures of competency, has been the focus of Cramer and colleagues' (2013) research. They found that most SRA training was derived from literature reviews, focus groups, and expert consultation which, although it had a high degree of agreement, was unwieldy for professional psychology's competency-based programs. Their aggregate of these data informed their 10 core competencies model of SRA: (a) recognizing attitudes and reactions, (b) developing and maintaining a collaborative empathic stand, (c) eliciting evidence-based risk and protective factors, (d) focus on current ideation and plan, (e) formulate chronic and imminent risk levels, (f) develop a collaborative treatment plan, (g) involve supports, (h) documentation of the former, (i) know ethic and legal obligations, and (j) debrief and self-care. They recommend that, similar to psychiatrists' and other health practitioners' training, these competencies be taught through an Objective Structured Clinical Evaluation (OSCE), which is an experiential method of demonstrating competency through treating a standardized patient who uses a preestablished script. As well, they developed a Suicide Competency Assessment Form (SCAF), a self-report measure of the aforementioned

competencies, where higher scores are positively associated with prior suicide prevention training, job enthusiasm, and suicide prevention outcomes (e.g., optimism when working with suicidal clients) (Cramer et al., 2020). Teaching these competencies increases clinicians' self-awareness of how they respond to suicidality, help them recognize and deliver appropriate empathic statements, increase their factual knowledge, and increase their self-confidence in conducting SRA (Cramer et al., 2017), an effect that is consistent across multiple healthcare settings and providers (Hager et al., 2021; La Guardia et al., 2019).

Clearly, the problem with SRA training is not that there is a lack of core competency training or measures, but rather, there is a lack of implementation. Although graduate-programs remain a key target for implementation, the results of my study also highlighted the importance of supervisors; internship was the second highest most influential SRA training, which was mostly supervision-based learning. Furthermore, interviewed participants consistently labeled their practicum and internship supervisors as their main SRA teacher and gatekeeper in helping them feel confident and ready for SRA practice. The training directors in Dexter-Mazza and Freeman's (2003) study also agree; 60% believed trainees should get their SRA training from practicum, compared to the 33% who believed it should come from lectures. Mackelprang and colleagues (2014) and Rudd and colleagues (2008) second these findings, noting not only the appropriateness of supervisors teaching SRA, but also that supervisors are the ones that typically measure trainee's competency and gate keep unethical or incompetent practice. Rudd and colleagues (2008) continue, highlighting three essential tasks supervisors should engage in when evaluating their trainees' competency: (a) improving the trainee's self-awareness and understanding, (b) ensuring content mastery, (c) monitoring and refining skill acquisition. They offer strategies to accomplish these tasks including routine discussion with the trainee about the meaning of the risk information collected and supervisor demonstrations (e.g., role-plays or co-therapy).

Given there has been little core competency SRA training in graduate programs and psychologists believe it is their responsibility to prevent suicide, it makes sense that many psychologists continue to learn and train in SRA on their own. About 60% of psychologists in my sample engaged in self-directed learning, most of which was academic readings, because of self-interest and to increase their competence and skill. This is similar to other works: 30% (Bruno, 1995), 33% (Brown et al., 2017), 48% (Mackelprang et al., 2014) of psychologists engaged in self-study and readings, with many more engaging in other self-directed learning (e.g., consultation) (Gerardi, 2018; Mackelprang et al., 2014).

These data reviewed in concert with mine highlight that there is both a hunger and a need for better SRA training. It can begin with accrediting bodies indicating crisis or risk-management as a core competency, providing practicable and experiential training, and measuring those outcomes. This can occur at both the graduate program level and at the supervisory level, as both were identified as key intervention points. As most psychologists receive some kind of SRA training (97% in my sample, 96% in Monahan and Karver's (2021) study), bettering training will have a fundamental impact on psychologists' suicide prevention practices.

Psychologists See Suicide as Symptom of a Psychosocial Issue, but Do Not Focus on Its Treatment

Underlying psychologists' SRA practices are their attitudes, beliefs, and conceptualizations of suicide. Psychologists, particularly, view suicide empathically compared to other mental health professionals (Gagnon & Hasking, 2012) and understand suicidal thoughts as a response to overwhelming psychological pain. In a previous study, I corroborated this finding, adding that psychologists also see suicide as a choice that requires intervention (Dubue & Hanson, 2020). Despite psychologists' empathic stance and attempts to understand how, or why, someone could become suicidal, psychologists believed safety was the utmost priority and that suicide was not a viable solution to their distress. This is consistent with findings from my current study, as interviewed psychologists understood suicidality as the hopeless belief that pain never ends, with over 75% prioritizing safety over

empathy. Participants in both my past and current study also spoke about how suicidality is a symptom of being cognitively overwhelmed, and that psychologists' role was to maintain their safety until the client could regulate themselves.

Despite these beliefs, 60% of psychologists did not assess the cause of their client's suicidal ideation. Assessing the drivers of suicide is a critical component of contemporary and collaborative SRA and management strategies, a practice that is one of the few but important changes to SRA in the last decade (Hawton et al., 2022; Jobes, 2012; Sommers-Flanagan & Shaw, 2017). This discrepancy between attitude and practice has two important implications. Firstly, psychologists are likely to be assessing for suicide drivers throughout their therapeutic contact, but not prioritizing them or meaningfully using it to manage their clients' suicidality. As identified by Rothes and Henriques (2018), 94% of psychologists do try to understand the motives that triggered a suicide attempt, and 91% ask questions about the problems clients are experiencing; my finding that psychologists do not ask about suicide drivers shows that, when asked openly about how you would address a suicidal client, motives and drivers are not a priority. Secondly, highlighting how psychologists do, in fact, understand suicide as psychosocial may help their transition towards collaborative and driver-based SRA and management. There is consistent evidence that attitudes inform behaviour in healthcare decision-making (Davidson et al., 1995; DiPasquale & Gluck, 2001; McKinlay et al., 2001), with suicide being no exception (Cwik et al., 2017; Hjelmeland & Knizek, 2004; Kerr, 2019). By focusing on and developing psychologists' attitudes towards suicide during training, we may help them integrate what is already being taught; most SRA training teaches collaborative skills, such as interpersonal connection and co-identifying recommendations (Liebling-Boccio & Jennings, 2013), both of which are consistent with psychologists' attitudes and contemporary SRA. Emphasizing psychologists' psychosocial conceptualization of suicide may be a facilitating factor in the discovery, adoption, and implementation of driver-focused suicide prevention and treatment models.

Treating a Suicidal Client Requires More Administrative and Emotional Resources

SRAs and working with suicidal clients is stressful, an effect that has been recounted in numerous publications across multiple populations, settings, and methodologies (Maris, 2019; Pope & Tabachnick, 1993; Shea, 1999). Indeed, compared to other clients, 73% of psychologists worried more about their suicidal clients and 78% found treating them more stressful. The most common reasons why clinicians experienced this stress included the absence of SRA training, lack of time, fearing litigation, or the belief that suicide is inevitable (Aflague & Ferszt, 2010; Awenat et al., 2017; Ellis & Patel, 2012; Michail & Tait, 2016; Petrik et al., 2015; Reeves & Mintz, 2001; Roy et al., 2017). My previous qualitative study added to this literature, identifying that psychologists feel responsible for maintaining their clients' safety yet cannot make that guarantee, feel pressured to be a perfectly ethical clinician when suicide is discussed, and invest an inordinate amount of emotional and administrative resources to do both.

These findings were replicated and expanded in my current study, given some novel integrative explanations. Firstly, we identified that psychologists' chief stressor when conducting an SRA is navigating the conflict between being both responsible for their clients' safety and caring about their autonomy and well-being. This process of moving between being an assessor of risk and a therapist was not only conflictual for psychologists, but also cognitively and emotionally demanding. They explained that the higher the perceived risk, the higher the stress, largely due to feeling forced to undermine their client's autonomy in service of their physical safety. This is consistent with the main theme from my previous study, where psychologists described the experience of weaving between assessment and therapy, ultimately experiencing debilitating role confusion. This is also consistent with the conclusions from Dundas and colleagues (2022) who found psychologists work differently with suicidal clients; they note psychologists are trained to respect their client's need for autonomy and advance therapeutic solutions, but in the face of a suicidal client, abandon these well-practiced and helpful behaviours.

Combined, these findings suggest that increasing the congruence between humanistic practice and SRA may decrease psychologists' stress.

Participants also reaffirmed other, albeit secondary, stressors when conducting SRA, particularly (a) emotional and (b) administrative stressors. Emotionally, psychologists identified how much harder it was to empathize and stay with their clients while they were suicidal, which Cureton and Clemens (2015) identify as unmanaged countertransference. Here, psychologists cannot reconcile their own values against those of their clients, a failure of empathy that leads to anxiety and therapeutic relationship ruptures. This, of course, is somewhat expected; psychologists have been identified as having high levels of death anxiety (Pepitone-Arreola-Rockwell, 1981), with SRA making death a salient topic (Cureton & Clemens, 2015). Administratively, psychologists noted that their SRA stress was contingent on what resources were available to them, such as appropriate community referrals, session time to complete the assessment and resulting clinical note, and access to self-care strategies. In my study, 42% of psychologists offer services not typically offered to non-suicidal clients, which isn't new; Bruno (1995) found that most of their sample increase the amount of written documentation and Regehr and colleagues (2022a) identified how clinicians rely on resource availability to decide on suicide prevention interventions. It is also no help that program directors believe their students are the least prepared to conduct some administratively heavy tasks, such as facilitating hospitalization (Liebling-Boccio & Jennings, 2013).

Reducing these stressors is an important part of better SRA practice and training, as, naturally, less stressed psychologists likely provide less rushed and more empathic SRA. My results highlight multiple stress-reducing interventions. Firstly, a few interviewed psychologists reported experiencing less role conflict when using therapeutic assessment-based SRA. Hawton and colleagues (2022) support this idea, suggesting psychologists could decrease SRA stress by leaning heavily into a collaborative and therapeutic relationship, de-emphasizing the role of the assessor in favour of building a robust alliance

that, if needed, can be minimize the harms associated with autonomy restrictive interventions. As well, participants in Regehr and colleagues' work (2022a) reported that fluid SRAs, that is, SRAs that are shaped by client responses, were more comfortable than standardized ones, giving clinicians a better chance to understand the assessment information received and attend to their clients' needs. Secondly, psychologists noted how their attitudes and beliefs about suicide were sometimes in direct competition with their practices, particularly when they could not connect with their client. To rectify this, Dundas and colleagues (2022) recommend that psychologists practice how to cope with being unable to form a working alliance during SRA, while reconciling the conflict of passionately wanting to help. In this case, consultation, role-plays, and personal therapy is indicated. Lastly, at least one psychologist from my study identified significant benefit from advocating for, learning about, and utilizing community resources, such that there is a broader safety net that could be cast if their client experiences suicidality. This is a recommendation also made explicit by the work conducted by Regehr and colleagues (2022a).

Psychologists Practice Fear-Based SRA

Elemental to psychologists' SRA practices and experiences is a fear of losing a client to suicide. This fear has two interwoven parts, both of which were the highest endorsed in this study: the fear of how psychologists will cope with a client's death by suicide and of subsequent litigation. The former, which 57% endorsed in this study, is tragically common (Pope & Tabachnick, 1993) with at least 23% of psychologists seeking related personal therapy (Bruno, 1995). This loss produces feelings of guilt, shame, and incompetence, often leading to a subsequent hypervigilance of suicide risk with increased focus on the legal aspects their practice (Finlayson & Graetz Simmonds, 2018).

Interviewed participants agreed a loss to suicide was/would be emotionally devastating, but explained it was secondary to the fear of litigation. Clinicians, after a loss, are quick to review their case notes to determine if they missed something, both a response to their grief and litigious fears (Darden & Rutter, 2011). Ellis and Patel (2012) explain that clinicians risk internalizing this grief, which could

manifest into avoidance, fear, and anger around SRA and suicidal clients, which some researchers postulating this process begins even at the onset of working with a suicidal client (Reeves & Mintz, 2001). Participants in my past qualitative study added, saying the fear comes from lacking control over their client's safety and from deciding on, or using, unpracticed paternalistic measures (Dubue & Hanson, 2020). They continued, detailing how SRAs became an urgent practice to quickly determine if the client is at risk of death, an experience that is consistent with the experiences of 57% of the current study's participants. Other findings were also generalized; over two thirds of my sample fear an improper SRA will lead to legal/professional issues if their client dies and thereby use these SRAs to protect themselves from legal liability. This matches Bruno's (1995) finding that 41% of psychologists would immediately contact their lawyer after a client's death by suicide and that psychologists practice legally-minded SRAs (i.e., information-based, risk-focused), as they are one of the first examined criteria of clinical negligence after a death by suicide (Reeves & Mintz, 2001). These litigious fears also harm the client, as clinicians may also intentionally overlook actual risk in service of avoidance or act in overly cautious ways (Yunik et al., 2022). Considering between 25% and 33% of psychologists have lost a client to suicide (Bruno, 1995; Gerardi, 2018), and 59% believe it is their professional responsibility to prevent clients from dying by suicide, psychologists experience a pervasive and debilitating fear of litigation when working with suicidal clients.

This litigious fear is perhaps present for two reasons, the first being that psychologists do not have a comprehensive understanding of the laws and ethics governing their suicide prevention practice. Eighty percent of the participants in my study endorsed that they know what the Code of Ethics says about suicide prevention, however, nearly all the interviewed participants endorsed conducting a SRA when asked what were their ethical responsibilities when a client brings up suicide. Truscott (2021) identifies this as a misunderstanding of our ethical obligations; he argues that if we are aware of our client's suicidality we have already detected it and knowing the degree of their suicidality adds no

protection from liability. Instead, Truscott (2021) recommends psychologists focus on reducing their clients' suicidality by doing what we are trained to do, that is, address our clients' anguish and replace feelings of despair with hope (Sommers-Flanagan, 2018; Truscott, 2018). These recommendations are consistent with our ethics, laws, and other jurisprudence. According to our Code of Ethics (CPA, 2017), we are allowed to share confidential information with a third party either with informed consent or in circumstances of possible imminent and serious bodily harm. This comes, in part, from a ruling by the Supreme Court of Canada in Smith v. Jones (1999) detailing how psychologists can break confidentiality when the risk is (a) serious and (b) imminent, and the person/group of persons is (c) clearly identifiable. Given health is regulated at the provincial level, it is also important to consider how each province governs their health practitioners, although Alberta's Health Information Act uses the same language as the Supreme Court of Canada's ruling. These rulings are complicated when engaging in suicide prevention, as we know risk, and therefore seriousness and imminence, is unlikely to be predictable (Franklin et al., 2017). Combining this evidence with our ethical and legal obligations, Truscott (2021) recommends that: "if we direct out efforts toward treating their emotional pain, rather than placating our distress, we have every reason to expect that they will feel less inclined to end their life, and will have met our ethical responsibilities" (Truscott, 2021, p. 16).

The second reason psychologists fear litigation is because zero-suicide prevention policies and the overall individualistic healthcare climate has shifted suicide from a moral to a medical problem. In the last few decades, organizations and governments have adopted suicide prevention strategies akin to the zero-suicide policy (Spiwak et al., 2012). This policy, both well-intentioned and optimistic, is based on the faulty premise that suicide can be readily detected and managed in health care, resulting in the widespread use of SRA tools and paternalistic healthcare responses (Dickerson et al., 2013). Smith (2022) argues this reflects a shift in philosophy about suicide, as what was once a moral issue (e.g., based on the opinions of the state, religion, and philosophy) is now a medicalized issue (e.g., a health

concern with a clear etiology, prediction, and treatment). This shift in power de-emphasized the previous moral reasoning, that suicide was the result of psychosocial stress, and instead pushed the myth that mental illness almost always precedes suicide (Hawton & Catalan, 1987). It also emphasizes suicide prevention strategies that are based on individual-level theorizing, making individual clinicians responsible for the prediction and prevention of suicide, rather than communities and public institutions (Fitzpatrick, 2018). Combined, suicide prevention is now relegated to screening programs that systematically undermine autonomy and risk psychological harm without any tangible health improvement for the client, transforming a complex health issue into a deceivingly simply one: "treatment of mental illness, coercively if necessary" (M. Smith, 2022, p. 8). This is the root of clinician's fear; we routinely face uncertainty when deciding to restrict our clients' liberties, a practice that is magnified when the responsibility to prevent suicide is felt to be exclusively on our individual shoulders. Jobes (2017) summarizes our best attempt at mitigating this fear: "a clinician may default to hospitalizing even a mildly suicidal person with a 'better safe than sorry' sensibility" (p. 210).

These fears can be mitigated in two ways: (a) comprehensively teach trainees and practitioners the ethics and laws governing suicide, and (b) advocate for decreased risk prediction and increased autonomy-supportive suicide prevention in healthcare settings. Firstly, it should be noted that the ninth core competency from Cramer and colleagues (2013) is knowing the law concerning suicide. They argue that knowing these laws not only helps clinicians feel confident about their practice, but also helps speed up stressful tasks such as third-party reporting. Like the discussion surrounding hospitalization, breaking confidentiality is not inherently harmful if done collaboratively, and can be an effective tool to manage a client's suicidality. Furthermore, teaching trainees and psychologists about the limits of their ethics and standards of practice may help mitigate their fears; it would be important for practitioners to understand that assessment needs to identify the imminency and seriousness of the risk, while the practitioner otherwise can focus on what they do best: treating the client's problems. Relatedly,

Hawgood and colleagues (2022) found that clinicians with more suicide-specific training had less risk assessment-related fears, suggesting more training is a viable intervention. Secondly, at the institutional level, researchers and psychologists could advocate for de-emphasizing risk prediction. Not only did most participants in this study identify that hospitals and other public institutions mandate the use of an SRA scale/measure, but also that these practices also increased the time it took to see a suicidal client, required more administrative resources, and reduced the depth of the therapeutic alliance at a critical intervention opportunity. This is especially vital as practitioners appear to be using SRA tools uniquely to deflect responsibility, even when they have no relevance to their decision-making (Regehr et al., 2022a). A combined approach of better SRA training and institutional change should have a demonstrable impact on clinicians' fears of practicing SRA and working with suicidal clients.

Limitations

This study was limited by at least three factors: (a) possible issues with representation of psychologists in Canada, (b), the unstandardized nature of the survey questions and (c) the purposive and snowball sampling strategy.

This study was developed, in part, to generalize the findings from my previous qualitative master's thesis (Dubue & Hanson, 2020). Given there are nearly 20,000 psychologists registered through the Canadian Institute for Health Information (2020), a minimum representative sample to meet the assumptions of a 95% confidence interval and 5% margin or error would be 377. With 160 participants, this was not achieved; the current results are within a 95% confidence interval, but with a margin of error of 7.6. This is not necessarily a significant limitation, as many of my sample demographics were consistent with at least two other studies of psychologists in Canada (e.g., race/ethnicity, practice setting, practice specialty, gender, province/territory practice location, and degree) (Jacobson et al., 2015; Ronson et al., 2011). The only demographic that could be compared to the entire psychologist population was province/territory practice location, of which my sample is representative (see Table 4)

(Canadian Institute for Health Information, 2020), with the exception of Québec. This was identified early in the data collection process, which led me to translate the survey into French Canadian and repeat my data collection efforts for this population. Unfortunately, I did not attain a representative sample of Québec psychologists.

The lower response rate of my sample and of Québec psychologists could be explained with multiple, likely overlapping reasons. Firstly, there is now a documented understanding of survey fatigue during the pandemic; de Koning and colleagues (2021) explain that, given many researchers pivoted to online surveys, participants felt fatigued when completing another online task as their personal and professional lives were also chronically online. Importantly, although the survey led with a relatively heavy open-ended response question, it did not appear this caused any significant attrition, as most left the survey before even seeing the question (Figure 2). If fatigue occurred for this survey, it was due to a lack of participants completing the survey past the inclusivity questions and not because of the overall survey design. Secondly, the study did not originally come with a translated option. This may have limited the amount of snowballing that could have occurred with Québec psychologists at the beginning of the collection phase. Lastly, the main recruitment method used to connect with Québec psychologists was through a paid listserv from their registration organization. This service could pinpoint potential participants by identifying their spoken language and research/practice interests. Although this presumably would have increased the likelihood of reaching interested participants, there is a possibility that the overuse of this service may have led to some psychologists blocking, or immediately deleting, these emails. It is also noteworthy that I could not connect with notable suicide and crisis-management services in Québec to help with data collection (e.g., CRISE). Having representation of Québec psychologists may have affected my results, given that Québec has a province-wide SRA protocol called la grille d'estimation de la dangerosité d'un passage à l'acte suicidaire (Lane et al., 2010), with several French-speaking survey and one interview participant identifying using this specific system. Therefore,

the results of this study may underestimate how many psychologists use standardized measures of SRA, given the underrepresentation of psychologists in Québec.

Secondly, the survey developed and used in this study was unstandardized. This limits the validity of comparisons to other survey designs with similar research questions. The main rationale for developing my own survey items was that there was not yet a survey developed that appropriately addressed the breadth of my research questions. Secondly, I wanted to balance covering multiple topics with survey length, which limited what scales I could have included in their entirety. The scales I would have included (e.g., Attitudes Towards Suicide Scale, Suicide Competency Assessment Form) would have increase the survey length, a metric I was already struggling to decrease while still answering all my research questions.

The last limitation is regarding the survey collection strategy, specifically purposive and snowball sampling. I used purposive sampling to allow for corrections to my sampling strategy in case I was not collecting a representative sample, whereas I used a subsequent snowball strategy to help bolster the reach of my collection efforts. Since both are non-randomized, there is a chance I collected a biased sample of psychologists. To, partially, mitigate this effect, I asked participants to identify how interested they were about the study and practice of SRA, nearly half of whom said they were very interested. I say this effect was partially mitigated as there is no comparative data to determine whether this sample was more or less interested in SRA and consequently biased, especially given nearly all psychologists work with suicidal clients. Once, or if, such normalization data is collected, this sample could be re-assessed as biased or not. This purposive participant selection also affects the interview sample, as this sample was non-randomly chosen to be as representative of the survey sample as possible.

Methodological Contributions to the Field

In tandem with these limitations, there are at least three major methodological contributions this study makes to the field of suicidology and suicide prevention including: (a) the development of a

comprehensive survey on SRA practices, training, and experiences, (b) an understanding of how psychologists practice SRA while minimizing the risk of social desirability, and (c) multiple novel explanatory insights regarding psychologists' practices, training, and experience.

Although this survey is unstandardized, it is also the first to comprehensively examine the whole developmental range of psychologists' SRA practice, including how they are trained, how they end up practicing, and the experiences in between. To increase the likelihood items on this survey be used for other studies, I placed a notable effort on detailing its development. This includes a background on the survey development process (Appendix 1), an empirical rationale for each item (Appendix 2), and the coding systems we used for the long-answer questions (Appendix 7, Appendix 8, and Appendix 9). Considering the field of suicidology and prevention is growing rapidly (Astraud et al., 2020), and best prevention practices are changing (Hawton et al., 2022), having a replicable survey design may aid the field in understanding if such changes are incorporated into practice.

A significant gap in past SRA practices research was the risk of social desirability. In such research, clinicians were asked to detail their SRA practices using checklists and closed-ended questions, where they risked a tendency to answer in ways that were self-promoting or viewed favourably by their peers. This is an especially important consideration when measuring a practice rooted in fear and litigation, such as SRA. By asking them a broad, open-ended question on their SRA practice, we not only limited the risk of social desirability, but also measured phenomena that would not be possible in a checklist/close-ended question. For example, we identified the overall type of SRA they conduct, how they begin their SRA, if they include humanistic interventions, or how they may explain concepts like ambivalence or hospitalization. Perhaps more importantly, we could better identify what they exclude from their practice, such as assessing for the psychosocial drivers of suicide, reminding clients about the limits to confidentiality, or including validations of their clients' pain. These all led to substantive insights; for example, we found that psychologists predominantly believe suicide is a psychosocial

concern yet very rarely assess for suicide-drivers, and that most psychologists are practicing similar SRAs although use a different language and order. To my knowledge, this is the first account of psychologists' SRA practices that is mindful of the risk of social desirability, making it one of the most organic and comprehensive.

Perhaps the most significant and unique contribution of this study is the wealth of explanatory and novel insights facilitated by the mixed method design. These insights, summarized in Table 9 (see the Integrated Conclusions column), augment and explain the processes behind how psychologists practice, learn, and experience SRA. For example, we previously knew that psychologists were confident in their SRA practice, but with our augmentative interviews, now also understand this confidence comes from experiential training like supervision or professional development. As well, we previously hypothesized that most SRA practices were focused on information-gathering, whereas we now know this for certain and better understand the process of adopting such practices is haphazard and rooted in fears of litigation. By first replicating and subsequently explaining these phenomena, this study offers a significant boon to the field in defining and detailing what and how psychologists practice, learn, and experience SRA; in doing so, we can generate novel research questions, engage in directed secondary analysis, and make empirically based recommendations for changes to our SRA practices, training, and policy.

Combined, these results are likely to produce a modest methodological contribution to the field, according to the typology described by Bergh and colleagues (2022). There are three types of audience that are likely to benefit from these results: (a) those who work with suicidal clients, (b) those who teach SRA and management, and (c) those who design policy on suicide prevention. Firstly, the biggest audience for this work are those who also stand to benefit the most: healthcare clinicians who work with suicidality. Here, clinicians may benefit from these results by comparing their practices to that of other psychologists and, in doing so, interrogate their own SRA practices, training, and experiences.

Ideally, this interrogation generates sufficient interest in engaging in continued professional development that is updated to our current best practices. A second, albeit smaller, audience, are those who train others in suicide assessment and management. The results in this study offer a direct examination into the outcomes of contemporary teaching efforts, including multiple calls to action such as increasing the frequency of experiential training and including more SRA training earlier in clinicians' development. Lastly, the smallest audience, policy makers, are arguably capable of making the most systemic change. In this study, we have identified that institutional pressures, such as needing to complete an information-gathering SRA in tertiary care settings or leaving the difficult decision-making of risk prediction to individual practitioners leads to fear-based practice. Reducing these fears is perhaps the most beneficial change we could make to the field of suicide prevention; by endorsing a collaborative and prevention-forward SRA practice, regulators and policy makers may decrease the immense strain that suicidality has on our healthcare system by reassuring both clinicians and clients that suicide is better prevented with humanistic intervention.

Future Research Directions

Given the breadth and depth achieved in this study, there exists many opportunities for replication and supportive future directions. In this section, in addition to highlighting important future research questions, I focus on broad research directions for the field of suicidology and psychologists' role in suicide prevention. The four that stand out as the most consequential are: (a) a secondary analysis of these data with group comparisons, (b) studies aimed at understanding and decreasing the harms of hospitalization, (c) theory-driven and interdisciplinary approaches to suicidology, and (d) increased emphasis on understanding the effect of culture and spirituality.

The first and most direct future direction is a secondary analysis of the quantitative results of this study. The current study, primarily descriptive and explanatory in design, offers several interesting research questions that are best answered through group comparisons. Some examples include: (a) To

what extent do Ph.D. level psychologists agree their graduate training prepared them to conduct SRAs, compared to masters-level psychologists? (b) To what extent do psychologists who have lost a client to suicide fear improper SRAs lead to legal issues or use SRA to protect themselves from legal liability? (c) To what extent do psychologists with "active" training agree that they need further training in SRA compared to psychologists with other kinds of training? Or (d) To what extent do psychologists who practice fluid SRAs worry about their clients with suicidal ideation or feel stressed when conducting an SRA? Importantly, such a study should begin with an estimation of which effect sizes would be sufficient to answer these questions (Cumming, 2014; Shrout & Rodgers, 2018), which may include collecting additional survey data. Ideally, this would also include more data from Québec psychologists to help with representing all psychologists in Canada.

An additional future direction includes what I believe to be suicidology's most critical point of intervention: crisis management and hospitalization. The reviewed research and the results of this study indicate that psychologists plan to continue using hospitalization to prevent suicide, despite the knowledge that it can be harmful for clients. From here, multiple research questions could be posed: (a) what are psychologists' experiences of referring clients to hospital for suicide? (b) to what extent are clients' experiences of hospitalization for acute suicide different if they are receiving ongoing care from a psychologist/mental health therapist? (c) how effective are crisis management interventions (e.g., preparing a client letter for the emergency department) at reducing the harm of hospitalization for clients? Such questions may also invite complexity, something that could be tackled with a mixed methods approach (Poth, 2018). Answers to these research questions could have a significant impact on changing SRA and management practices, while also helping mitigate psychologists' fear and stress when working with a suicidal client.

A broader and more conceptual future direction is my recommendation that suicide research focus on interdisciplinary suicide theory. A recurrent thesis woven throughout this dissertation is that

risk factor-led SRA is poor at predicting and explaining suicide risk, and rarely serves client needs. In contrast, suicide theory focuses on explaining how people engage in suicidal thinking without prediction, leading to discussions of intervention. This is why I and others, such as Braslow and colleagues (2021), Douglas (2015), Fitzpatrick and colleagues (2015), Klonsky (2021), and Shneidman (1996), argue that theory-driven intervention is best for what is a low base-rate and phenomenologically complex behaviour. Klonsky (2021) argues this point with his Three Step Theory of Suicide, providing evidence that a combination of pain, hopelessness, lack of social connection, and the capability for suicide readily explains suicide, and that integrating this understanding at every point of intervention (e.g., emergency, community, population) is likely to reduce the deaths by suicide. Importantly, this act must be collaborative between disciplines; Fitzpatrick and colleagues (2015) argue all suicidologists, nestled in their own fields, have the same goal of better understanding suicide, which easily brings "suicidology [as] a coherent, singular and powerful social practice" (p. 304). Recognizing suicidology as a social practice means understanding how its knowledge creation is influenced by moral, political, and institutional powers. For example, some findings in suicidology (e.g., biological, quantitative) are more prized than others (e.g., sociological, qualitative), given they fit within the predominant medical model of mental health. As well, suicide researchers inherently occupy multiple moral and social roles as clinicians, religious leaders, advocators, or political figures (Hjelmeland & Loa Knizek, 2020). Future research, given this lens, may be querying how psychologists understand the impact of their other roles on their practice of SRA or identifying to what extent interdisciplinary theory-driven SRA impacts suicide behaviour and ideation.

Lastly, another future direction is the replication of this study across different cultural backgrounds. Most participants reported a European-Canadian cultural background, which, although was presumably representative of psychologists in Canada, highlights a cultural homogeneity that limits these findings to the majority group. This is not new; 81.9% of suicide research published between 2010

and 2014 has been conducted in North America and Europe, and only 6% has been conducted in China and India, despite reporting near half of the world's suicides (Lopez-Castroman et al., 2015). It is possible the overemphasis on deterministic and risk factor-focused SRA is a reflection of a post-positivist Western-centric lens (Ma-Kellams & Blascovich, 2012). Comparatively, Eastern, or primarily collectivist cultures, emphasize collaborative models of healing, promote ideals of selflessness, and view death with less anxiety, given that their identities are strongly linked to communal in-groups (Hofstede, 1980; Peng & Nisbett, 1999). As well, only one participant in this study endorsed asking about cultural or spiritual factors during their SRA, supporting the finding from Chu and colleagues' (2017) that very few psychologists are culturally-sensitive when practicing SRA. Replicating this study with other groups and cultures not only gives us insight into how SRA may be practiced differently according to cultural values, but also informs how we may better serve diverse clients. Future research examining this topic should identify ethnocultural variables as part of a main hypothesis and should be considered at the research conceptualization stage (Hall et al., 2016).

Implications for Practice, Training, and Policy

The results of this study have significant implications for the practice, training, and policy of SRA and suicide prevention. Based on these results, I recommend the following.

Practices

SRA can, and should be, therapeutic. At least three options exist for clinicians to learn how to modify their practice:

1. The most structured and well-defined example is the Collaborative Assessment and Management of Suicidality (CAMS) model from Jobes (2012). The developer, Dr. David Jobes, runs a training organization (CAMS-CARE) that includes course content, role-plays, and consultation, in addition to multiple continuing education opportunities and knowledge translation of recent SRA and management research.

2. Another, less structured, option is learning the Therapeutic Assessment (TA) framework. Finn (2007), one of TA's main developers and advocates, argues that modern assessments are needlessly information-focused, resulting in authoritarian and directive practices. This is especially harmful for suicidal clients, as the presence and absence of key relationships is a fundamental variable that prevents or causes suicide (Jobes, 2000). The TA model teaches clinicians how to develop a therapeutic relationship during assessment, and how to utilize the tools of assessment to benefit the client (Dressel & Matteson, 1950; Finn & Tonsager, 1997). To learn and practice TA, clinicians have the option of completing training from the Therapeutic Assessment Institute, where they are provided with references to independently learn TA content, are subsequently tested on a competency exam, and can be certified by submitting videos for review or working with a TA-trained supervisor. Of course, clinicians do not need to be fully certified in TA to practice client-centered or therapeutic SRA, as TA principles are very often integrated in psychotherapy as therapeutic interventions (Poston & Hanson, 2010). This is best evidenced by a recent article detailing how to incorporate TA in SRA, with practical recommendations for clinicians (Hawton et al., 2022).
3. Another option is the Strengths-Based SRA and management model from Sommers-Flanagan (2019). This continuing education course or, more recently, book (Sommers-Flanagan & Sommers-Flanagan, 2021) describes a wealth of the research reviewed in this dissertation and pairs it with a practicable guide to building client strengths while assessing, treating, and managing their suicidality. Arguably, this is the most accessible option, as the changes clinicians need to make to their practice are consistent with psychotherapy's typical client centered practices, compared to learning a new protocol (e.g., CAMS) or philosophical framework (e.g., TA). This model is also consistent with the host of resilience and strengths-based literature (Lee

Duckworth et al., 2005; Murphy & Sparks, 2018) and self-determination theory (Dudgeon et al., 2020; Ryan & Deci, 2017), reinforcing its theoretical backing.

Training

4. The most robust, well-evidenced, and practicable SRA training is Cramer and colleagues' (2013) core competency model. This model is consistent with the calls to action from participants and researchers alike, who asked that SRA and management be considered a core competency in graduate studies, that it be taught using experiential pedagogy, that it highlights ethical/legal factors, and that outcomes be routinely measured. With continued research examining the effectiveness of their training workshop (Cramer et al., 2017) with behavioural health (Cramer et al., 2020), community (La Guardia et al., 2019), and university health service providers (Hager et al., 2021) across online (Cramer et al., 2019) and hybrid (La Guardia et al., 2021) modalities, this training model offers graduate psychology faculty and workshop developers a consistent, clear, and evidence-based approach to teaching SRA.
5. A unique finding in this study was the high degree to which supervisors influence psychologists' SRA practices. As such, SRA training directed specifically towards supervisors would be an effective way of implementing better SRA practices. In addition to recommending supervisors engage in the previous practice recommendations, Rudd and colleagues (2008) discuss how SRA training can be adapted to the supervisory setting. Given there is not usually a formal didactic component to supervision, this model emphasizes experiential practice and observation with plenty of insight-focused discussion. For faculty who wish to ensure their students' supervisors are prepared to teach their supervisees SRA, this article is a key resource.

Policy

6. Canadian Psychological Association's accreditation should require programs to demonstrate their students are proficient and prepared to engage in suicide prevention. Presumably, this

would ensure graduate students in professional psychology programs receive standardized training (e.g., through Cramer and colleagues' Core Competency Model), minimize the stress they experience while working with suicidal clients, and help clients who are accessing the services of students feel safe when disclosing their suicidal thoughts.

7. Provincial and territorial licensing bodies should clarify what is expected of psychologists when a client mentions suicide. Albeit anecdotal, numerous colleagues have pointed to the College of Alberta Psychologists' Monitor on suicide prevention (Truscott, 2021) as a breath of fresh air amidst an uncertain and anxiogenic practice. As much as peers, training, and academic readings could highlight the ethical imperative that psychologists practice driver-focused treatment and suicide prevention rather than prediction, having their regulatory organization clarify this as a standard of practice would have a demonstrable impact both on actuarial practice and on psychologists' well-being.

Conclusion

The last 10 years have presented a remarkable shift in how we prevent suicide and this study aimed to examine how well psychologists have kept up. We found psychologists are using litigation-focused information-gathering SRA developed from an assorted collection of training where fear guides much of their interactions with suicidal clients. This is in stark contrast to collaborative, strengths-based, and relational SRA, where clients' autonomy is respected and returns psychologists to their intended role as helpers of distress. Unfortunately, psychologists are behind in their SRA practices, due in part to lackluster training, which contributes to stressful SRA experiences.

The next 10 years, I suggest, should focus on the implementation of these collaborative developments. Already, the ideals of humanistic SRA are reaching multiple and divergent parties, as several journal articles from just the last year have called for these same recommendations (Espeland et al., 2021; Foster et al., 2021; Hawton et al., 2022; Pashak et al., 2022; Rudd, 2021). And such growth is

being supported; a recent narrative review identifies how implementation science can support suicide prevention research, identifying key future directions such as real-world effectiveness of interventions, engagement of crisis service stakeholders, and the identification of cross-setting and universal barriers (Larkin et al., 2022).

Such efforts should not be completed in a silo, which is why I recommend suicidologists recall the sociological origins of this field. A contemporary criticism of the domineering powers in psychiatry is its myopic (biological and medical) view of mental illness that limits how we understand and treat patients (Braslow et al., 2021), which has played a significant influence in the over-reliance on SRA scales and prediction (M. Smith, 2022). I, and many authors cited here, see the future of suicidology as interdisciplinary, collaborative, and focused primarily on better understanding the suicidal person's experience and applying those insights across implementation outcomes. Sociology is particularly primed to play a stronger role, with recent reviews demonstrating actionable interventions for suicide at the institutional level (Chandler, 2020). This is critical, as there are growing sociology-level healthcare threats that directly impact suicidality, such as climate change (Belova et al., 2022), the opioid crisis (Oquendo & Volkow, 2018), healthcare funding, and accessible education (Lange et al., 2023). Both call for advocates of suicide prevention to engage in the socio-political sphere, where psychologists would benefit immensely from our sociology colleagues. But for these changes to happen in earnest, we must first shift our "models for suicide prevention…[as they] tend to neglect social and ecological determinants or [only] include them in superficial and cursory ways" (Wray et al., 2011).

As we lick the wounds of decades worth of dissatisfying research conclusions, such as being unable to predict (Franklin et al., 2017) or prevent (Fox et al., 2020) suicide, I call for quiet, radical action; to focus again on suicide's most poignant questions:

"'Where do you hurt' and 'How can I help you?'" (Shneidman, 1996, p. 6).

Tables

Table 1

Summary of Superordinate Theme Descriptions for Psychologists' Experiences Conducting Suicide Risk Assessment (from Dubue & Hanson, 2020)

Superordinate Theme	Superordinate Theme Description
Research Question 1: What Are Psychologists' Experiences of Conducting SRAs?	
Weaving Assessment and Therapy	Integrating the goals, practices, and world views of therapy and assessment into the SRA practice. Feeling obligated both to ensure client safety through assessment and to build connections through therapy. The two processes are semi-permeable to each other.
Relying on Clinical Intuition	Having a "gut feeling" about suicide risk and using this intuition to guide assessment and therapeutic practice.
Investing in the Suicidal Client	After hearing a suicide clue, feeling a need to invest in the client deeply and urgently. Includes higher professional resource allocation, worrying after session, and feeling exhausted.
Research Sub-Question 2: How Do Psychologists View Suicidal Clients?	
Positive View of Suicidal Clients	Being supportive of suicidal clients, including understanding suicide as a product of psychosocial distress while assessing for clinically significant factors, such as low affect and dysregulation.
Suicide Is a Choice, but I Need to Intervene	Belief suicide/suicidal ideation can be explained, but is likely due to overwhelming stress, ambivalence, or insufficient understanding of consequences.
Research Sub-Question 3: How Are Psychologists Affected by SRAs?	
Fear of Client Suicide Drives SRA	Uncertainty of proper SRA practice, inability to control client behaviour, and feeling responsible for client safety guide a fear-based SRA.
The Pressure of Responsible Caring	Due to perceived consequences of a poor SRA, feeling a need to be a perfect helper to the client and a perfectly ethical psychologist to supervisors, colleagues, and regulating bodies.
SRA Is Setting-Dependent	The goals, frequency, and clinician/client comfort with SRA changes depending on the practice setting.
Research Sub-Question 4: How Do Psychologists View Their SRA Training?	
Graduate SRA Training Is Inefficient and Insufficient	Graduate-level SRA training is not proportionate to the amount it is practised. Prior volunteer/practicum experiences are lasting formative SRA training experiences.

Table 2

Regulatory and Societal Organization Recruitment Participants and Outcomes

Organization	Outcome
B.C. Psychological Association	Email sent to all members (800)
Psychologist Association of Alberta	Posted on website for three months
Saskatchewan College of Psychologists	Posted on website for one month
Manitoba Psychological Society	Email sent to all members (213) & posted on website for one month
Ontario Psychological Association	Email sent to all members
L'Ordre des Psychologues du Québec	Email sent to English-speaking members interested in suicide (688 – 7%) in May 2021 Email sent to French-speaking members interested in suicide (784 – 9%) in July 2021
College of Psychologists of New Brunswick	Email sent to all members
Association of Psychologists of Nova Scotia	Email sent to all members
Association of Psychology Newfoundland and Labrador	Included in quarterly newsletter
Psychological Association of PEI	Email sent to all members
Association des psychologues du Québec	Redirected to regulatory body
College of Psychologists of British Columbia	Redirected to societal association
College of Alberta Psychologists	Redirected to societal association
Psychological Association of Manitoba	Redirected to societal association
College of Psychologists of Ontario	Redirected to societal association
Nova Scotia Board of Examiners in Psychology	Redirected to societal association
PEI Psychologist Registration Board	Redirected to societal association
Newfoundland & Labrador Psych Board	Redirected to societal association
Association of Psychologists of Northwest Territories	No response.

Table 3

Demographics Characteristics of the Survey and Interview Sample

Characteristic	Survey Sample		Interview Sample	
	n	%*	n	%*
N=	**160**	**100**	**9**	**100**
Gender				
Female	129	**80.6**	6	**66.7**
Male	30	**18.8**	2	**22.2**
Gender Diverse	1	**.6**	1	**11.1**
Highest Degree Attained				
M.Ed.	5	**3.1**	1	**11.1**
M.A./M.Sc.	35	**21.9**	2	**22.2**
Psy.D.	10	**6.3**	1	**11.1**
Ph.D.	99	**61.9**	5	**55.5**
M.Ps.	6	**3.8**	-	**-**
M.C.	3	**1.9**	-	**-**
Other	2	**1.3**	-	**-**
Ethnic/Cultural Background				
Asian/Asian Canadian	7	**4.4**	-	**-**
Hispanic/Latinx	5	**3.1**	1	**11.1**
Métis	1	**.6**	-	**-**
White/European Canadian	144	**90.0**	8	**88.9**
Other	3	**1.9**	-	**-**
Primary Practice Setting				
Armed Forces	2	**1.3**		
Child/Adolescent Psychiatric or Pediatric	12	**7.5**	1	**11.1**
Community Mental Health Center	18	**11.3**	1	**11.1**
General Hospital	7	**4.4**		
Medical School	1	**.6**		
Outpatient Clinic	17	**10.6**	1	**11.1**
Prison/Correctional Facility	8	**5.0**	1	**11.1**
Primary Care Network	2	**1.3**		

Private Practice	63	**39.4**	4	**44.4**
Psychiatric Unit/Hospital	8	**5.0**		
School/School District	13	**8.1**		
University/College Psychology Department	3	**1.9**		
University/College Counselling Center	4	**2.5**		
Other/Multiple	2	**1.3**	1	**11.1**
Primary Theoretical Orientation				
Behavioural	5	**3.1**		
Biological (i.e., Neurological, Chemical)	1	**.6**		
Cognitive Behavioural	73	**45.6**	2	**22.2**
Eclectic	12	**7.5**	1	**11.1**
Existential	3	**1.9**		
Feminist	1	**.6**	1	**11.1**
Humanistic	17	**10.6**	2	**22.2**
Integrative	26	**16.3**	1	**11.1**
Process-Experiential	3	**1.9**		
Psychoanalytic/Psychodynamic	7	**4.4**	1	**11.1**
Systems	2	**1.3**		
Dialectical-Behavioural	4	**2.5**	1	**11.1**
EMDR	3	**1.9**		
Acceptance Commitment	2	**1.3**		
Narrative	1	**.6**		

Note. Survey participants were on average 45 years old (*SD*=11.6), attained their degree in 2007 (*SD*=10.6), and have been practicing for 13 years (*SD*=10.2). Interview participants were on average 47 years old (*SD*=7.2), attained their degree in 2005 (*SD*=8.1), and have been practicing for 15 years (*SD*=8.3).

*Total percentage may not total 100% due to rounding errors.

Table 4

Survey and Interview Participant Practice Location Compared to Canadian Institute for Health Information (CIHI, 2020)*

Characteristic	Survey Sample			Interview Sample			CIHI in 2019	
	n	%**	%** (cumulative)	n	%**	%** (cumulative)	n	%**
N=	**176**	**100**	**110.0**	**10**	**100**	**111.1**	**19,077**	**100**
Practice Location								
British Columbia	15	8.5	**9.4**	1	10.0	**11.1**	1,252	**6.6**
Alberta	35	19.9	**21.9**	2	20.0	**22.2**	3,928	**20.6**
Saskatchewan	9	5.1	**5.6**	1	10.0	**11.1**	515	**2.7**
Manitoba	6	3.4	**3.8**	-	-	**-**	266	**1.4**
Ontario	41	23.3	**25.6**	3	30.0	**33.3**	4,001	**20.9**
Québec	35	19.9	**21.9**	2	20.0	**22.2**	7,728	**40.5**
New Brunswick	20	11.4	**12.5**	1	10.0	**11.1**	364	**2.0**
Nova Scotia	8	4.5	**5.0**	-	-	**-**	624	**3.3**
Prince Edward Island	3	1.7	**1.9**	-	-	**-**	55	**.29**
Newfoundland and Labrador	2	1.1	**1.3**	-	-	**-**	281	**1.5**
Northwest Territories	2	1.1	**1.3**	-	-	**-**	63	**.33**
Nunavut	-	-	**-**	-	-	**-**	26	**1.4**

*CIHI collects jurisdictional data but does not differentiate between a Provisional Registered Psychologist, Courtesy Registrants, Psych Associates, or Registered/Certified Psychologist. A private communication with CIHI revealed that CIHI reports the total number of psychological health professionals reported by the Province/Territory's jurisdictional college. Further, participants in our study were registered with multiple jurisdictions; this is not differentiated in the CIHI data.
**Total percentage may not total 100% due to rounding.

Table 5

Participant CPA Section Affiliation or Expertise/Practice Domain

Characteristic	Survey Sample			Interview Sample		
	n	%	% (cumulative)	n	%	% (cumulative)
N=	**359**	**100.0**	**231.6**	**25**	**100.0**	**277.8**
CPA Affiliation or Expertise						
Indigenous Peoples' Psychology	6	1.7	**3.9**	1	4.0	**11.1**
Addictions Psychology	11	3.1	**7.1**	-	-	**-**
Adult Development and Aging	6	1.7	**3.9**	-	-	**-**
Brain and Cognitive Sciences	5	1.4	**3.2**	-	-	**-**
Clinical Psychology	108	30.1	**69.7**	7	28.0	**77.8**
Clinical Neuropsychology	8	2.2	**5.2**	1	4.0	**11.1**
Community Psychology	5	1.4	**3.2**	-	-	**-**
Counselling Psychology	39	10.9	**25.2**	3	12.0	**33.3**
Criminal Justice Psychology	10	2.8	**6.5**	1	4.0	**11.1**
Educational and School Psychology	17	4.7	**11.0**	-	-	**-**
Family Psychology	8	2.2	**5.2**	1	4.0	**11.1**
Health Psychology and Behavioural Medicine	26	7.2	**16.8**	2	8.0	**22.2**
International and Cross-Cultural Psychology	3	0.8	**1.9**	-	-	**-**
Psychologists in Hospitals and Health Centers	23	6.4	**14.8**	2	8.0	**22.2**
Psychology in the Military	4	1.1	**2.6**	-	-	**-**
Psychologists and Retirement	1	0.3	**0.6**	-	-	**-**
Psychopharmacology	2	0.6	**1.3**	-	-	**-**
Quantitative Methods	1	0.3	**0.6**	1	4.0	**11.1**
Rural and Northern Psychology	7	1.9	**4.5**	-	-	**-**

Sexual Orientation and Gender Identity	11	3.1	**7.1**	2	8.0	**22.2**
Social and Personality Section	5	1.4	**3.2**	1	4.0	**11.1**
Teaching of Psychology	5	1.4	**3.2**	1	4.0	**11.1**
Traumatic Stress Section	26	7.2	**16.8**	1	4.0	**11.1**
Section for Women and Psychology (SWAP)	4	1.1	**2.6**	1	4.0	**11.1**
Other	13	3.6	**8.4**	-	-	**-**
None	5	1.4	**3.2**	-	-	**-**

Table 6

Interview Participant Demographics

Partici-pant	Gen-der	Age	Highest Degree Earned	Years Practi-ced	Province of Practice	Ethnicity	Practice Location	Theoretical Orientation
1	M	51	M.Ed.	19	Saskat-chewan	White	Prison/Correctional Facility	Cognitive Behavioural
2	F	42	Psy.D.	2	Ontario	Hispanic / Latinx	Private Practice	Feminist
3	F	45	Ph.D.	16	Ontario	White	Child/Adolescent Psychiatric or Pediatric	Cognitive Behavioural
4	F	38	M.A./ M.Sc.	11	Alberta	White	Community Mental Health Center	Humanistic
5	F	49	Ph.D.	16	Alberta & Québec	White	Private Practice	Humanistic
6	F	57	Ph.D.	26	New Brunswick	White	Neuro-Rehab centre	Integrative
7	F	37	Ph.D.	5	British Columbia	White	Private Practice	Dialetcical-Behvioral
8	M	56	Ph.D.	26	Ontario	White	Private Practice	Eclectic
9	GD	47	M.A./ M.Sc.	15	Québec	White	Outpatient Clinic	Psychoanaly-tic/Psycho-dynamic

*M = Male, F = Female, GD = Gender Diverse

Table 7

Main Research Questions and Their Correspondence to the Follow-Up Research Questions

Main Research Question	Follow-Up Research Question
What are psychologists' **practices** of SRA?	How did psychologists choose their SRA practices?
	How and when do psychologists become confident in their SRA practice?
	What are psychologists' reasons for using or not using SRA scales or measures?
	How do psychologists understand the role of hospitalization in preventing suicide?
How are psychologists **trained** in SRA?	How and when were psychologists prepared to conduct suicide risk assessments and prevention interventions?
How do psychologists **experience** SRA?	How do psychologists understand the etiology of suicide?
	What makes working with suicidal clients stressful to psychologists?
	How do psychologists understand their ethical responsibilities regarding suicide prevention?

Table 8

Summary of the Interview Results

RQ 1: How do psychologists choose their SRA practice?	
SRA practices are haphazardly chosen	Participants explained that they did not choose their SRA practice, rather they adopted the practices from practicum and internship supervisors, developed their own from client feedback, embraced a workplace-specific practice, or formed one from post-graduate self-directed professional development. Given suicide assessment and prevention practices are eclectic and indistinct, psychologists' process of choosing an SRA practice is usually passive and informal.
RQ 2: How and when do psychologists become confident in their SRA practice?	
Confidence comes from practice with feedback	Their confidence was developed through repeated practice, often with high-risk clients, and by receiving feedback from supervisors, peers, and other interdisciplinary team members. Some participants were mindful of being overconfident, citing how suicide is unpredictable and they are fallible practitioners.
Confidence comes years after graduate school	All participants noted they were only confident after several years in independent psychotherapy practice.
RQ 3: What are psychologists' reasons for using or not using SRA scales or measures?	
Setting and training first determine SRA scale use	Participants identified that their workplace or training first determined their SRA scale usage. Some health settings mandated scales, whereas other participants were either never trained in SRA scale use or explicitly trained to use one. Importantly, all participants who used SRA scales were represented in this theme.
Standardized SRA lacks context and harms the therapeutic alliance	The remaining participants who did not use SRA scales did so because they believe it fails to gather important contextual information and harms the therapeutic alliance. Although some recognized SRA scales facilitates communication within interdisciplinary institutions, this came second to the threat of SRA scales disparaging client connection. Participants talked about how fluid SRAs and qualitative interviews better contextualized their clients' suicide risk.
RQ 4: How do psychologists understand the role of hospitalization in preventing suicide?	

Hospitalization is a last, necessary resort that harms clients	Psychologists understand hospitalization as a last resort, used only when all other safety options have been exhausted. They describe how hospitalization is a cost-benefit decision, where the benefit of keeping the client physically safe must outweigh the harm the psychologist and the hospital causes by violating their right to autonomy.
RQ 5: How and when do psychologists believe they should be trained in suicide prevention?	
Psychologists are not ready for SRA practice during graduate training	Seven of the nine participants indicated they were ready to work with suicidal clients only after their graduate training, whereas the others detailed how in-vivo supervision and experiential training helped them feel ready, earlier.
Psychologists' best SRA training is supervised experiential practice	In describing their preparedness, nearly all participants highlighted how they learned suicide assessment and prevention from their practicum or internship supervisors. They also noted how in-vivo feedback (peer and supervisor) and experiential practice (e.g., role-plays) were important in getting them ready to see suicidal clients.
Suicide assessment and prevention is a core competency that should be mandatory learning in graduate school	Participants further elaborated that their graduate training seldom included intentional suicide assessment or prevention training. As suicide assessment and prevention is an inevitable experience and core skill in psychologists' practice, participants recommended graduate training include dedicated coursework prior or during practica.
RQ 6: How do psychologists understand the etiology of suicide?	
Suicidality is the hopeless belief that the pain will never end	Participants understood ambivalence and hopelessness as the main etiology of suicide. They noted how clients do not want to die, but rather end a never-ending pain, punctuated by feeling stuck, purposeless, or isolated. Some participants conceptualized this hopelessness as emotional dysregulation.
RQ 7: What makes working with suicidal clients stressful to psychologists?	

The conflict of being responsible and caring	The conflict of being unable to guarantee their client's safety while feeling responsible to do so is what makes working with suicidality stressful. This stress is proportional to the client's perceived risk level, as higher risk levels pressure psychologists to risk the client's autonomy and dignity by enacting paternalistic safety measures (e.g., hospitalization). Further, participants identified suicidal clients require more administrative resources and emotional labour (e.g., empathic stress, boundaries).
RQ 8: How do psychologists understand their ethical responsibility regarding suicide prevention?	
Assess to minimize harm, but seldom to maximize benefit	Most psychologists identified their ethical obligation is to complete a suicide assessment for the purposes keeping their client safe from physical harm, thereby minimizing harm and avoiding liability. A few psychologists were in opposition; they noted their ethical responsibility was to treat the client's suicidality, highlighting the importance of maximizing benefit. Despite the different in opinion, all parties had some sense of responsibility for their clients' well-being.

Table 9

Integrated Results

Research Question	Survey Results	Interview Themes	Integrated Conclusions
What are psychologists' **practices** of SRA?	76% use structured SRAs, 18% use standardized SRAs, and 7% use fluid SRAs 86% use information-gathering SRAs whereas 14% practices therapeutic SRAs	SRA practices are haphazardly chosen	The haphazard nature of SRA training and available practice leads to most psychologists practicing idiosyncratically structured SRA. The psychologists who use SRA protocols often did so because they were explicitly trained in them or were required to use them by their work. The remaining majority do not use a specific SRA protocol because they believe they fail to gather important contextual information and disrupt the therapeutic alliance.
	28% use a specific SRA protocol 59% rely on their clinical intuition when determining suicide risk 56% trust SRA scales or measures when determining suicide risk	Setting and training first determine SRA scale use Standardized SRA lacks context and harms the therapeutic alliance	
	95% are confident in their SRA practice. 59% believe their graduate training prepared them to conduct SRA	Confidence comes from practice with feedback Confidence comes years after graduate school	Nearly all psychologists were confident in their SRA practice, a process that participants noted took years of repeated practice with feedback from supervisors, peers, and mental health team members.
	81% do not fear involving third parties when their client is experiencing clear and imminent suicidal ideation 97% know what to do when clients experience clear and imminent suicidal ideation 55% recommend, endorsed, or mentioned hospitalization in their SRA practice	Hospitalization is a last, necessary resort that harms clients	Although psychologists know hospitalization is a harmful last resort, most do not fear making third party referrals because the guarantee of their client's safety exceeds the harm to the therapeutic alliance.

	59% believe their graduate training prepared them to conduct SRA 49% believe they received sufficient SRA training prior to seeing their first suicidal client 53% believe they need further training in SRA 43-49% received graduate-level SRA training.	Psychologists are not ready for SRA practice during graduate training Psychologists' best SRA training is supervised experiential practice Suicide assessment and prevention is a core competency that should be mandatory learning in graduate school	Interviewed psychologists resoundingly reported receiving lackluster and insufficient SRA training in graduate school. Considering suicide assessment and prevention is an inevitable practice, it is striking that 41% do not believe their graduate training sufficiently prepared them. Those who received sufficient training endorsed experiential, supervised, and practicable SRA training as the cause, albeit typically from practicum supervisors. To fix this, interview participants supported more dedicated suicide prevention coursework prior or during practica.
How are psychologists **trained** in SRA?	40% completed professional development because it was required by work. 57% received their most influential training after graduate school, 43% during, and 11% before. Most influential training: 33% professional development, 19% full/part-time internship, and 14% crisis center. Training was influential because it was experiential (33%) and practicable (31%).		

	60% of psychologist do not assess for the cause(s) of suicidal ideation/drivers to suicide. 88% agree that conducting SRAs helps prevent client deaths by suicide. 57% agree SRAs help them predict the risk of death by suicide.	Suicidality is the hopeless belief that the pain will never end.	Psychologists understand suicidality is a hopeless belief that the pain will never end, yet most do not ask about the pain. This conflict is rarely reconciled as most believe their SRA helps prevent death; others find solace in the practice of therapeutic-focused SRA.
How do psychologists **experience** SRA?	78% find treating a suicidal client is more stressful than treating other clients. 19% feel stressed when asking if their client is thinking of suicide. 40% feel stressed when conducting a detailed SRA. 63% put more effort into their clients who are suicidal. 42% offer services to suicidal clients not typically offered to non-suicidal clients.	The conflict of being responsible and caring	Most psychologists find treating a suicidal client more stressful than treating other clients, which interviewed participants explain is because of the added conflict of being responsible for their physical safety while caring for their emotional well-being. The added stress comes from needing to invest more administrative resources and emotional labour in the client, which a majority of psychologists do.
	68% fear an improper SRA will lead to legal or professional issues if their client dies by suicide. 67% use SRAs to protect themselves from legal liability. 80% know what the Code of Ethics says about suicide prevention 59% believe it is their professional responsibility to prevent clients from dying by suicide	Assess to minimize harm, but seldom to maximize benefit	Most psychologists fear the legal or professional consequences of conducting an improper SRA and most also use SRAs to protect themselves from those same consequences. Interviewed participants explained this is because most psychologists practice SRAs to exclusively minimize harm and forget about maximizing client benefit.

Figures or Illustrations

Figure 1

Gantt Chart of Study Procedures

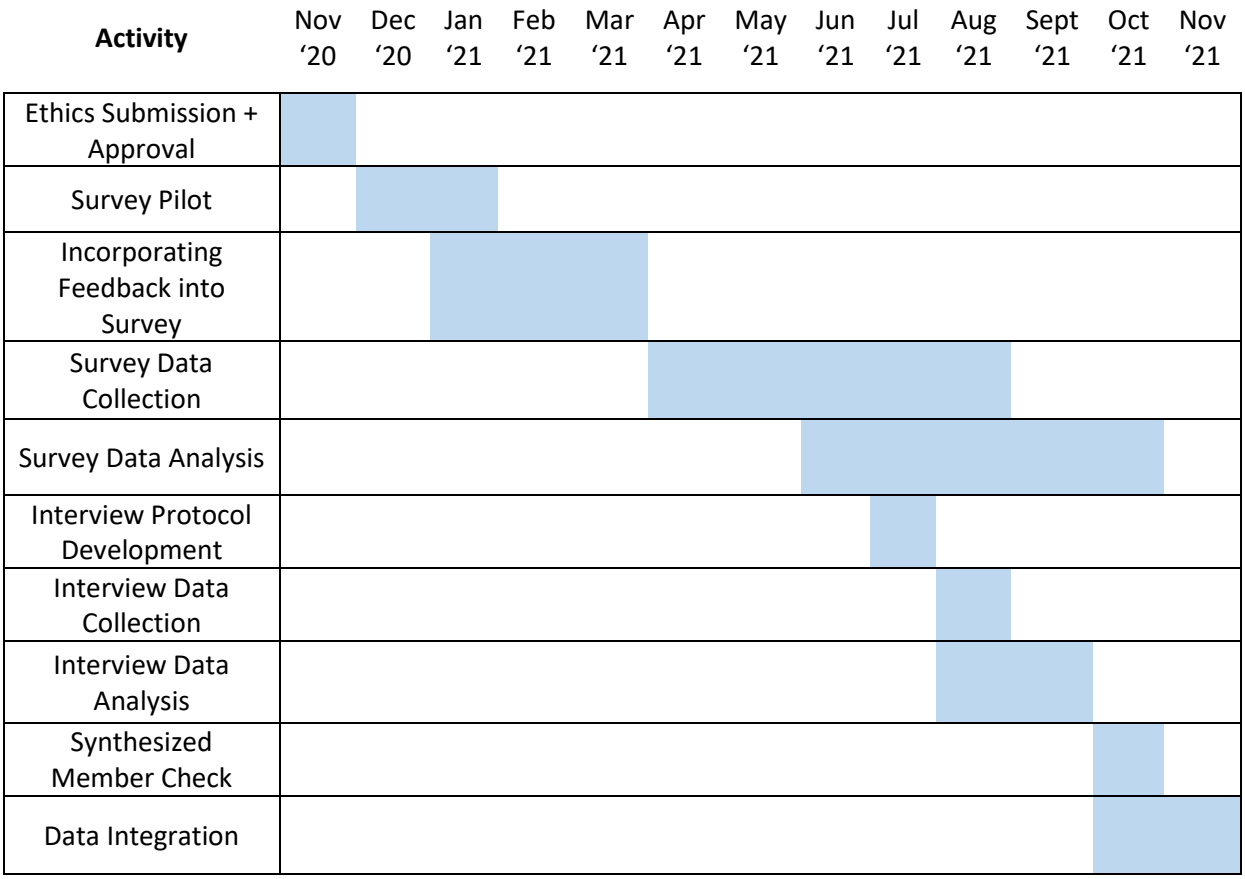


Figure 2

Sankey Chart of Survey Participant Retainment

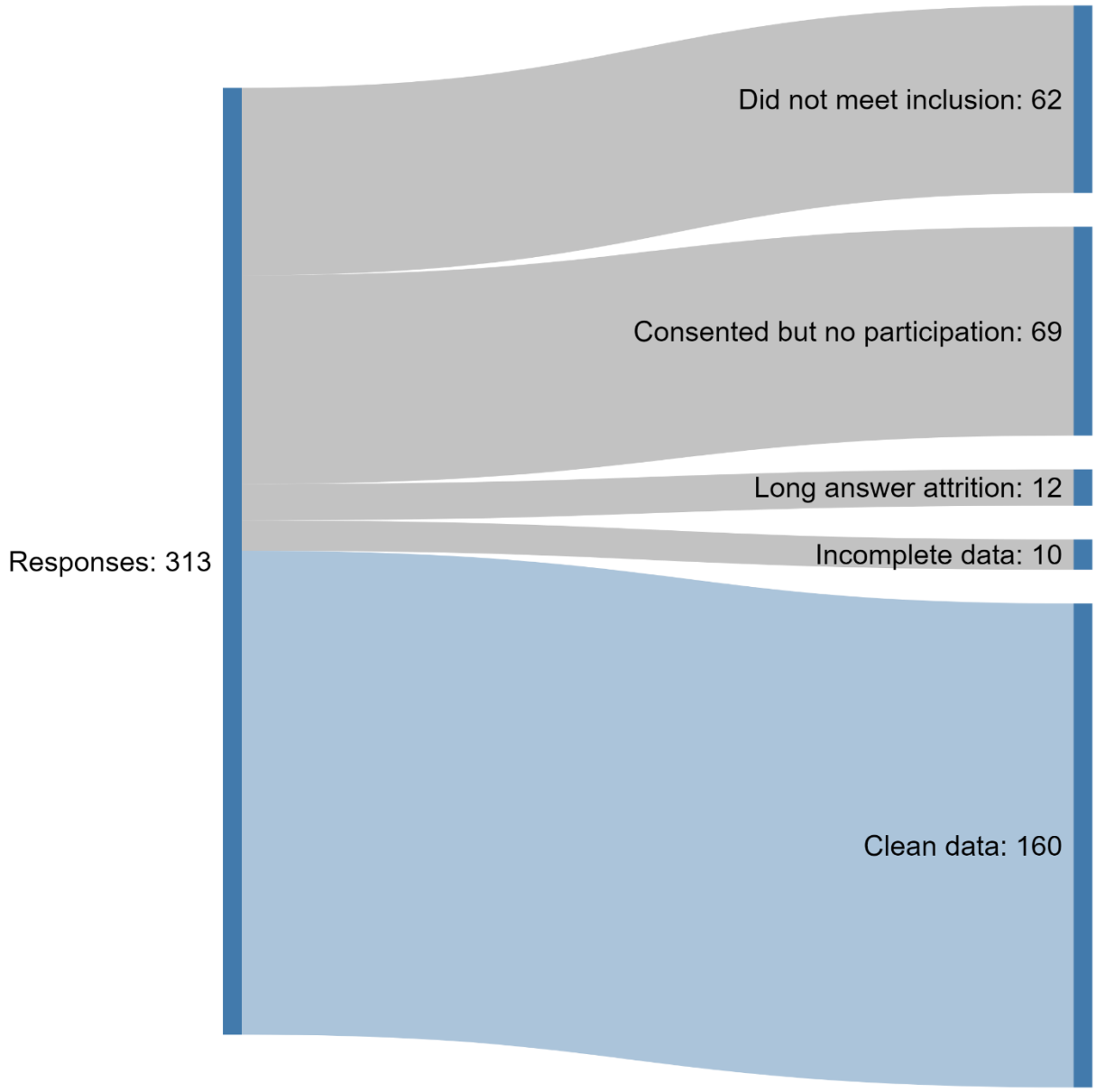


Figure 3

Survey Completion Date

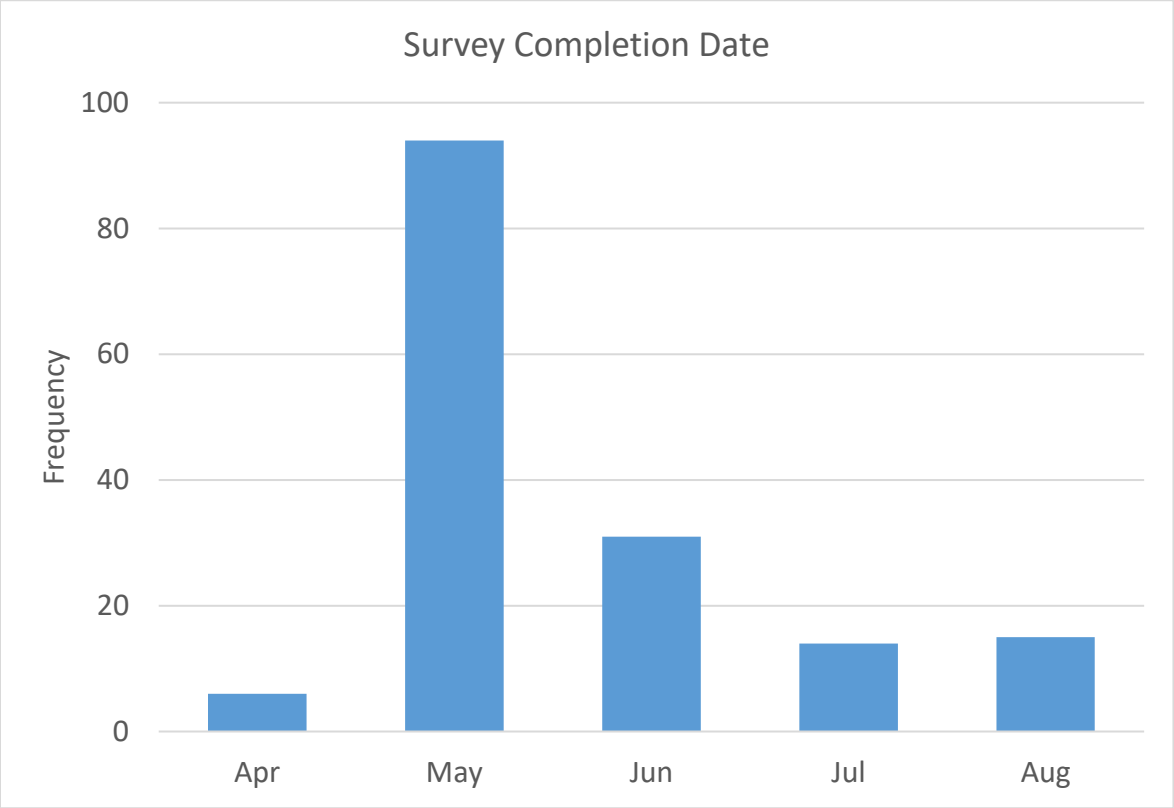


Figure 4

When Did Participants Last Conduct an SRA?

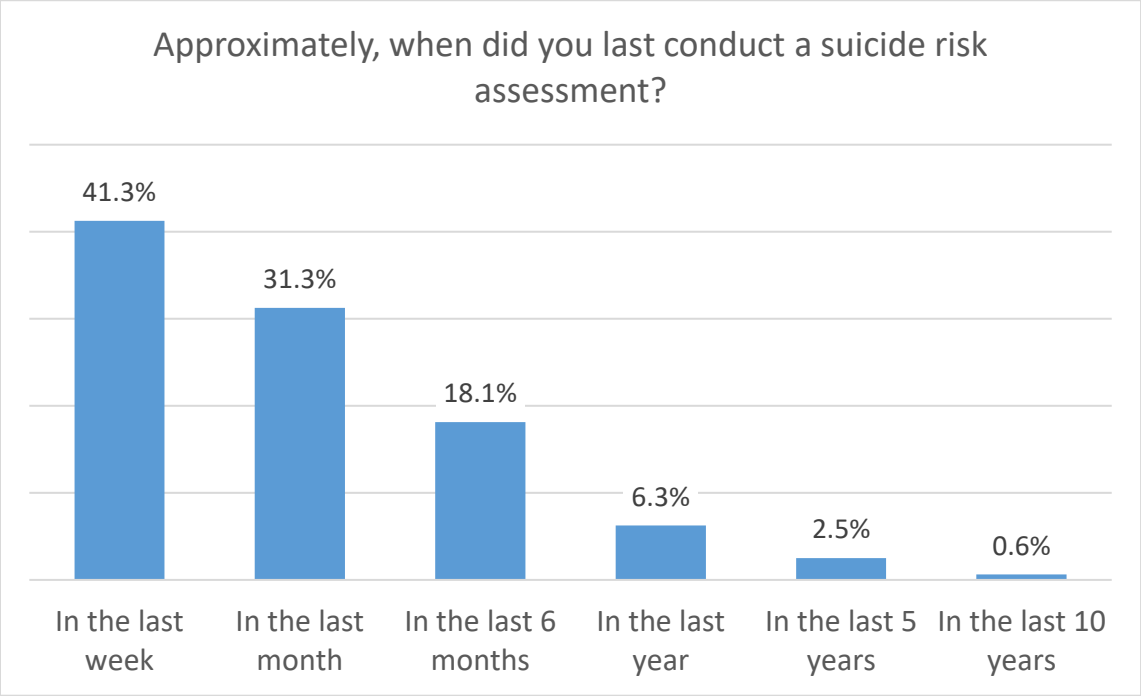


Figure 5

How Interested Are Participants in the Study and Practice of SRA?

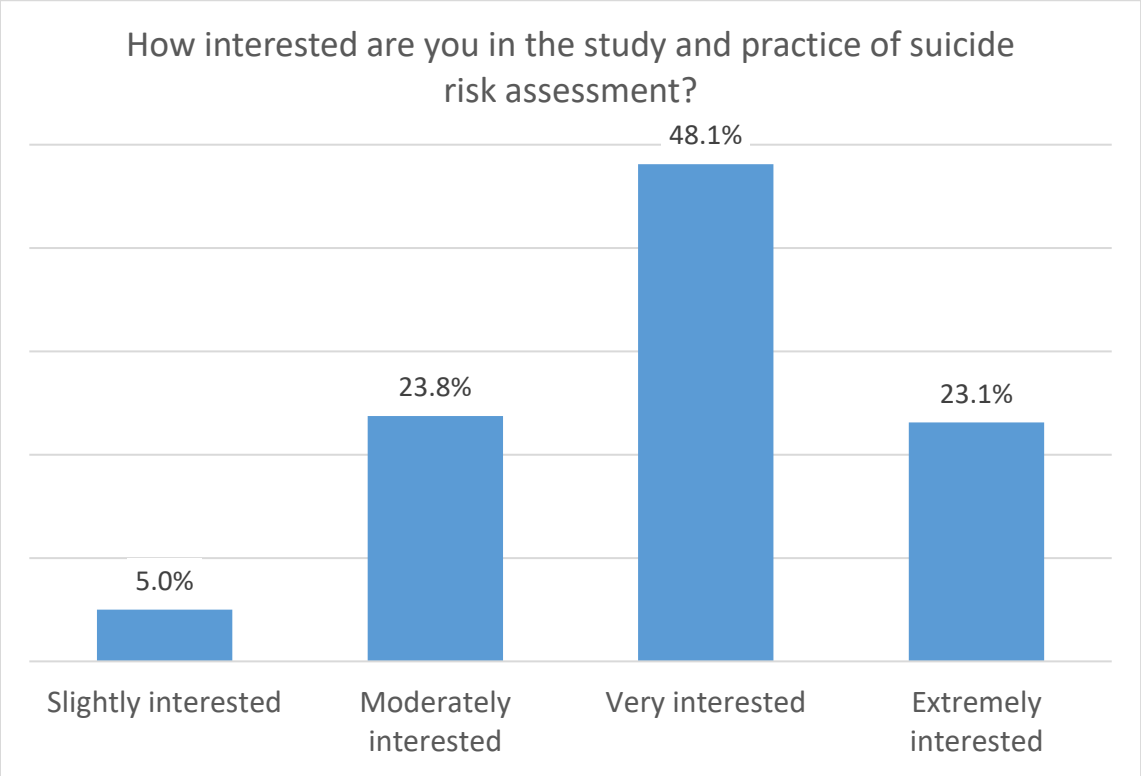


Figure 6

How Often Do You Use SRA and How Often Do You Assess for Suicide on First Visits?

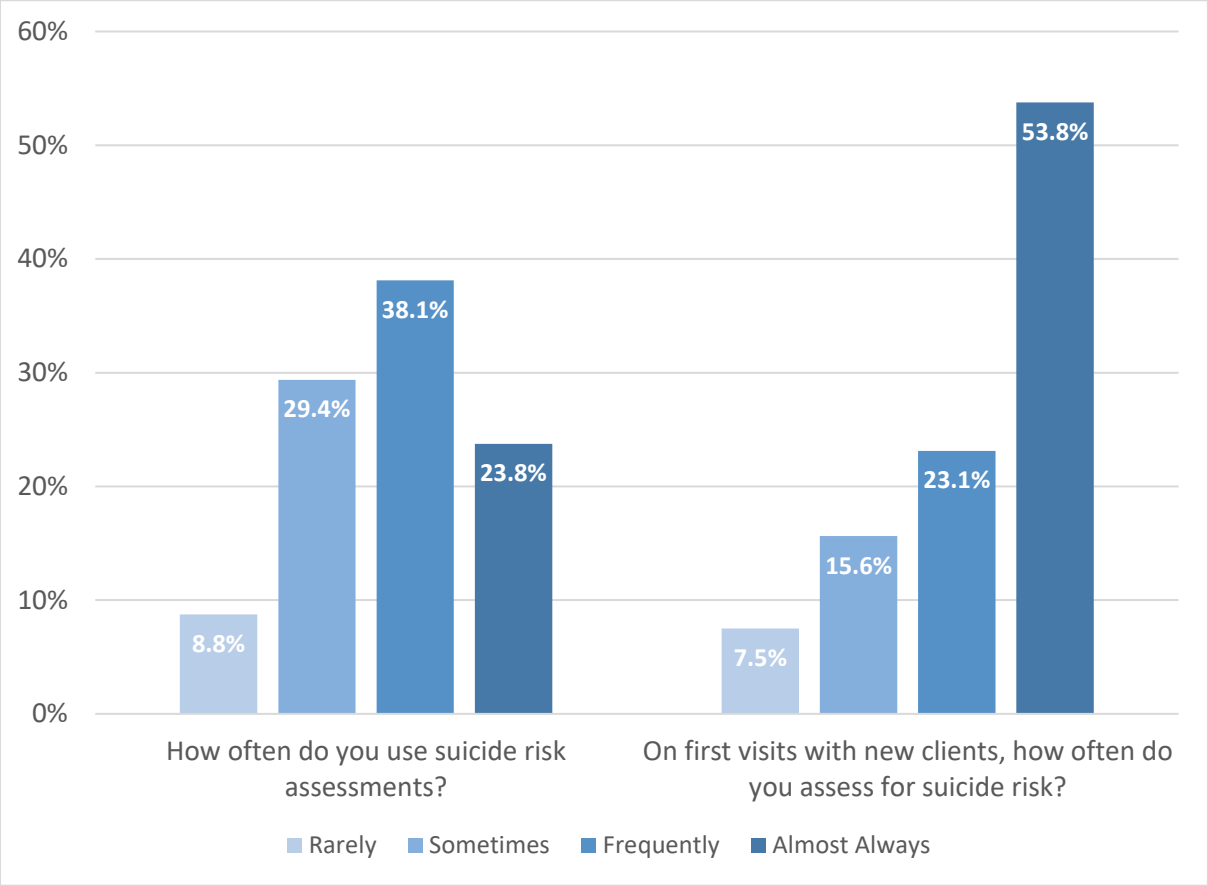


Figure 7

Response Quality of Answers to 'Practices' Question 7

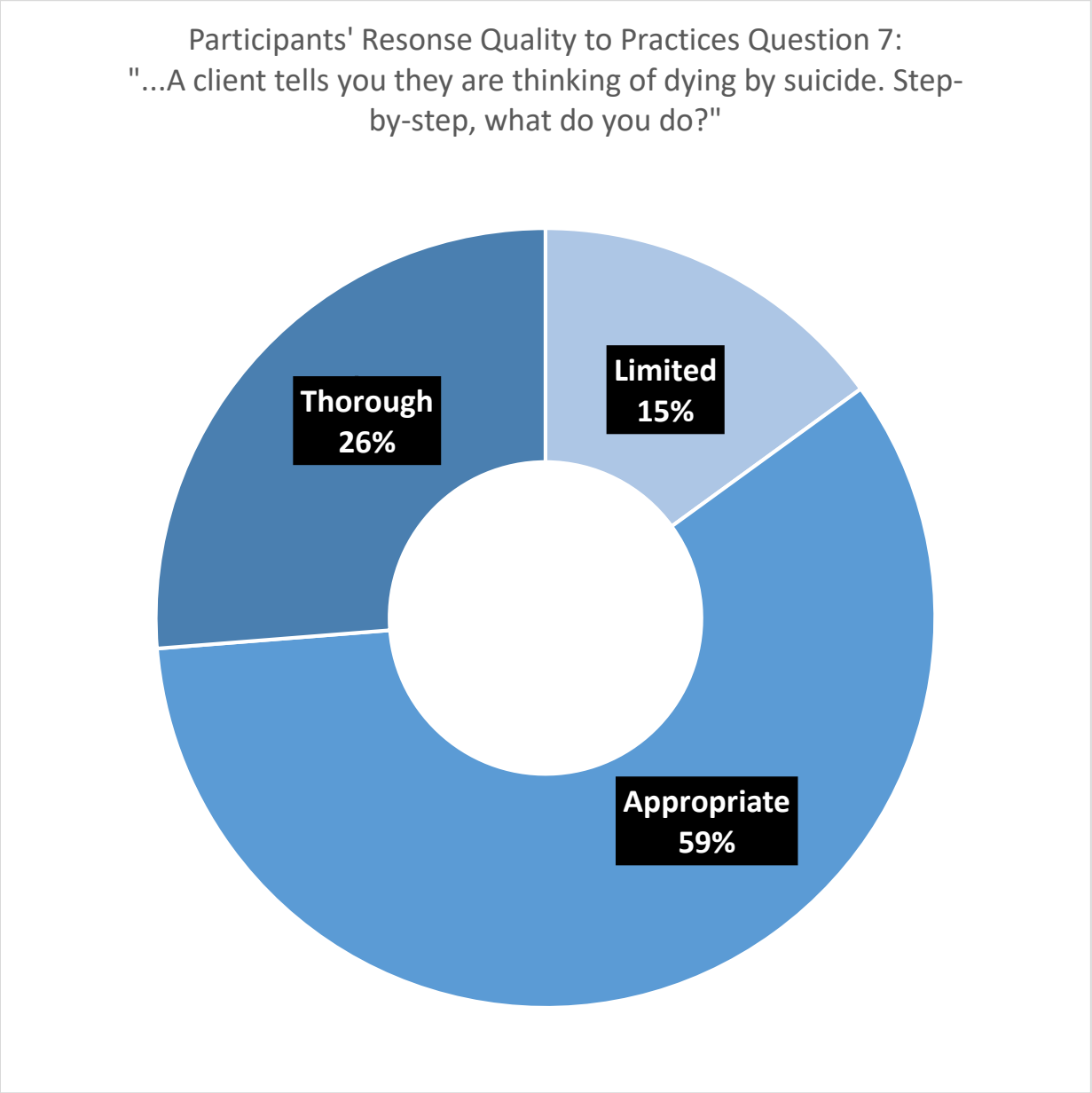


Figure 8

Structure of SRA According to Answers of 'Practices' Question 7

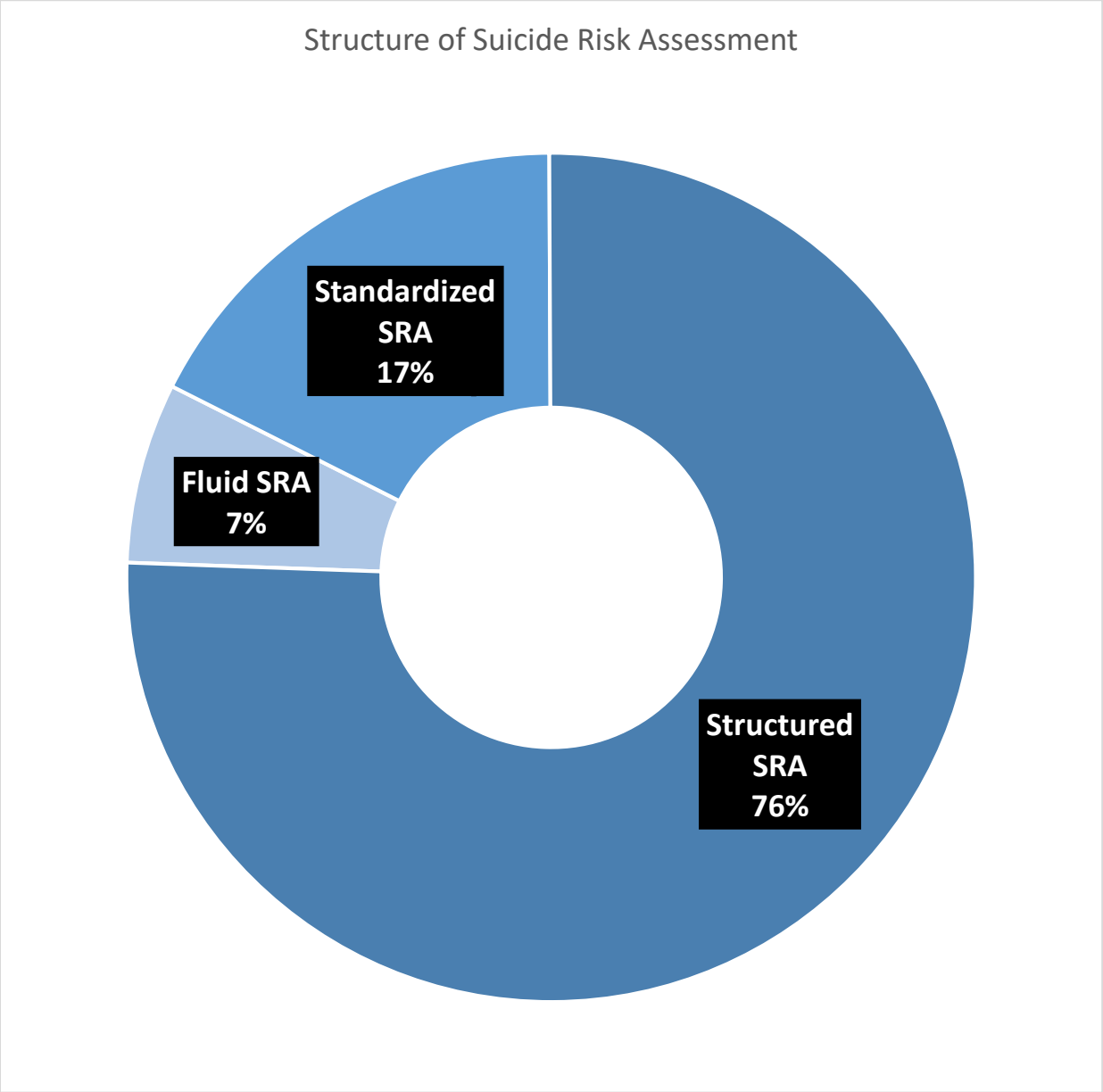


Figure 9

Focus of SRA According to Answers of 'Practices' Question 7

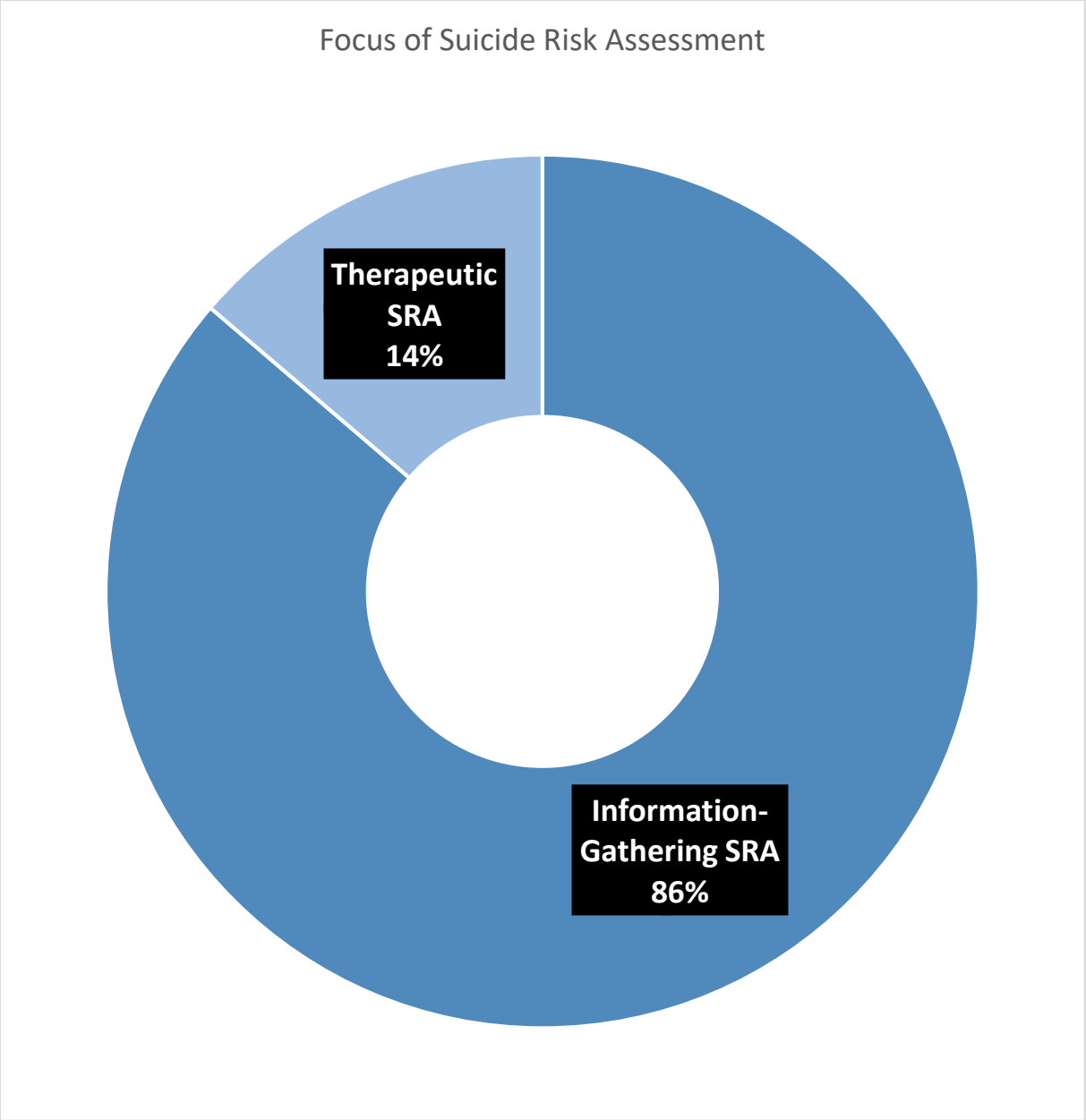


Figure 10

First Step of SRA According to Answers of 'Practices' Question 7

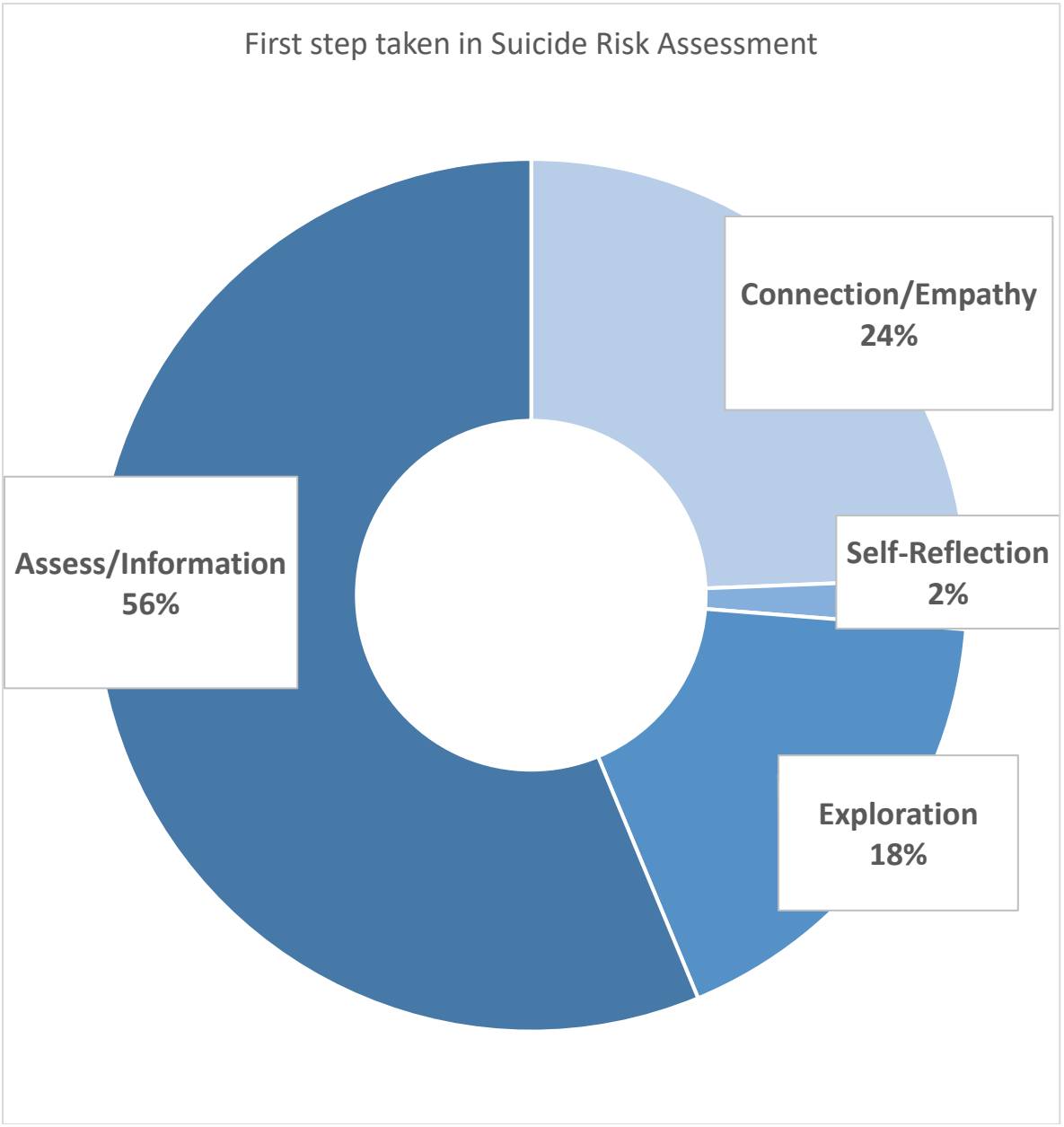


Figure 11

Participants' Specific SRA Practices

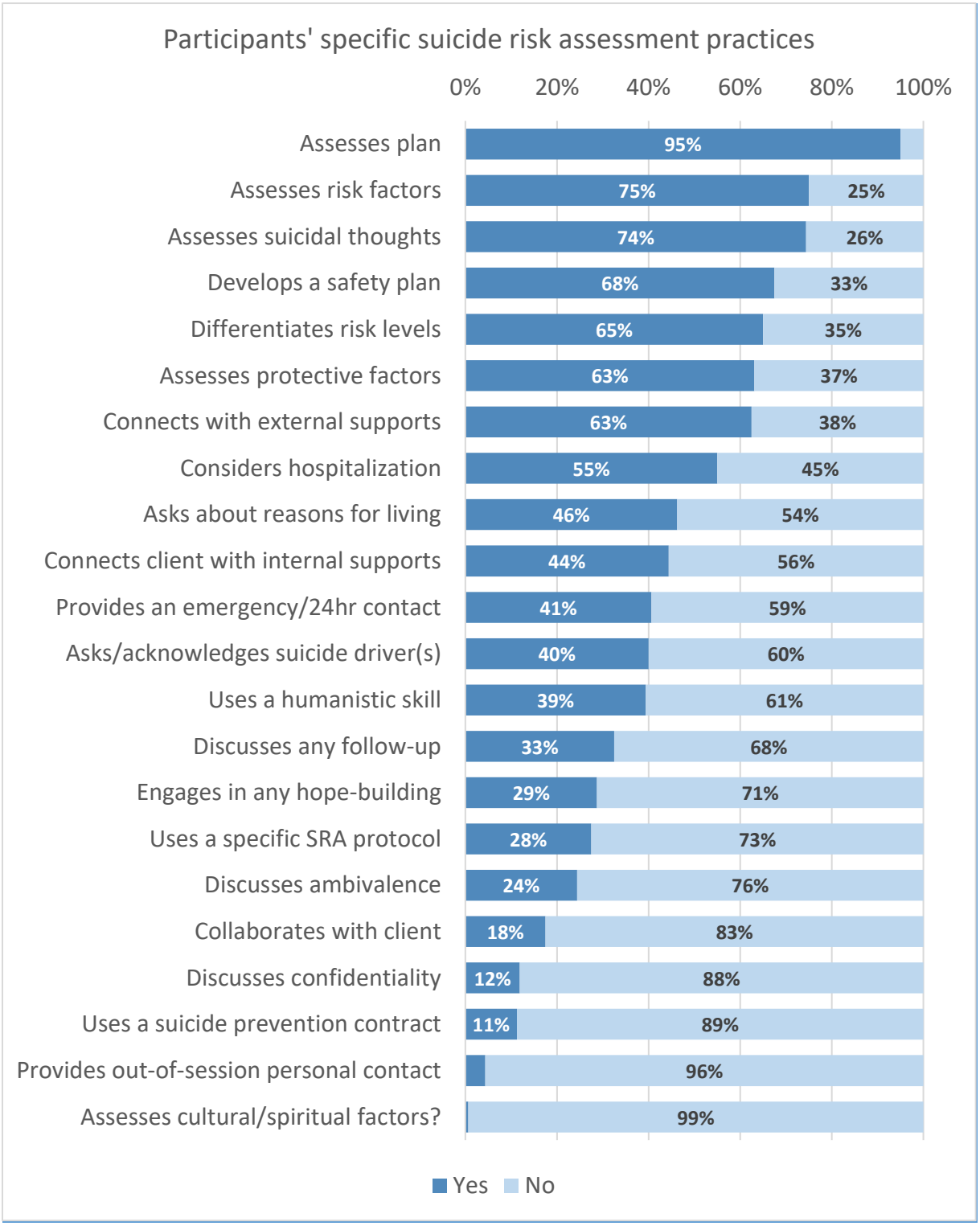


Figure 12

Participants' SRA Training

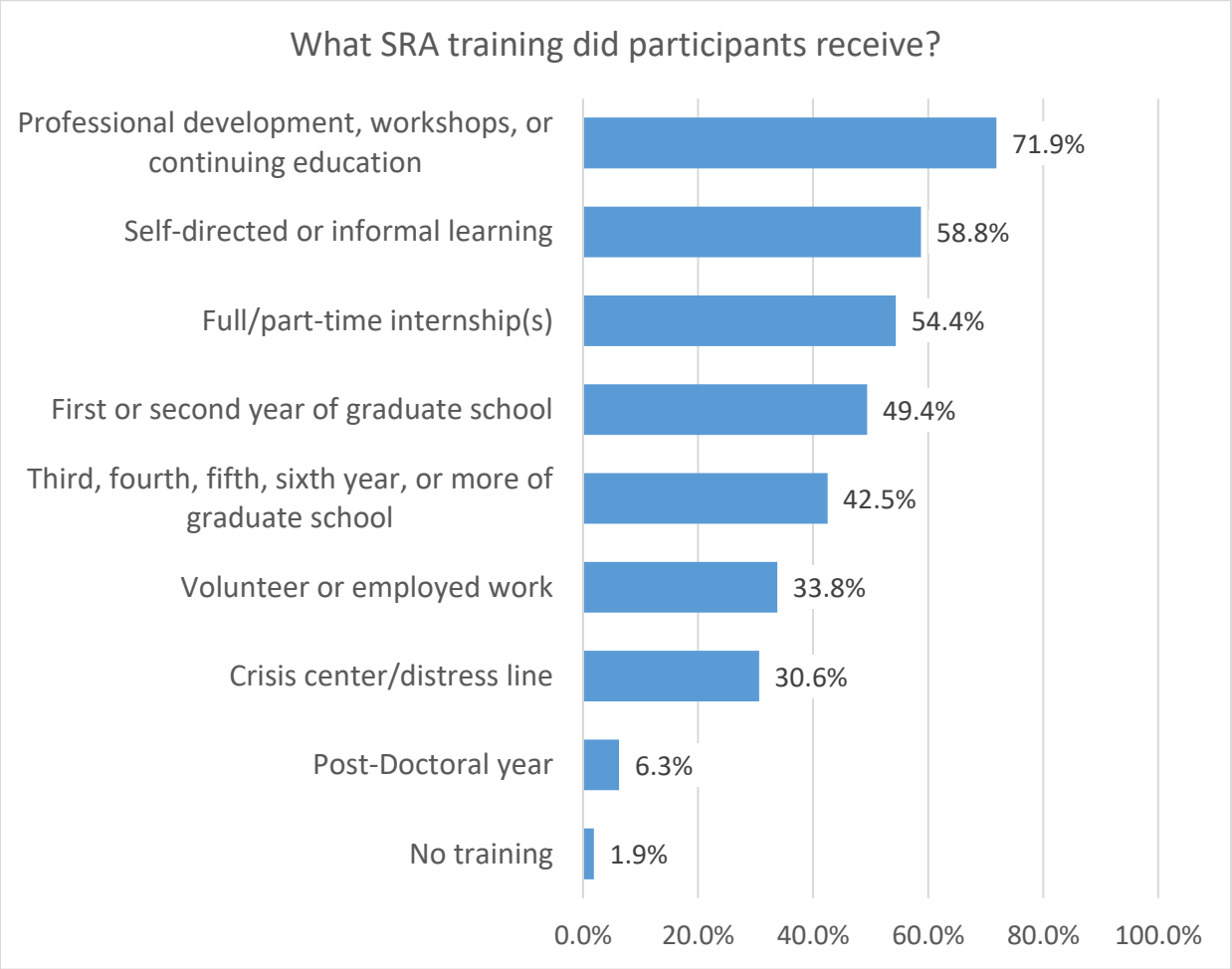


Figure 13

What Kind of SRA Training Did Participants Receive?

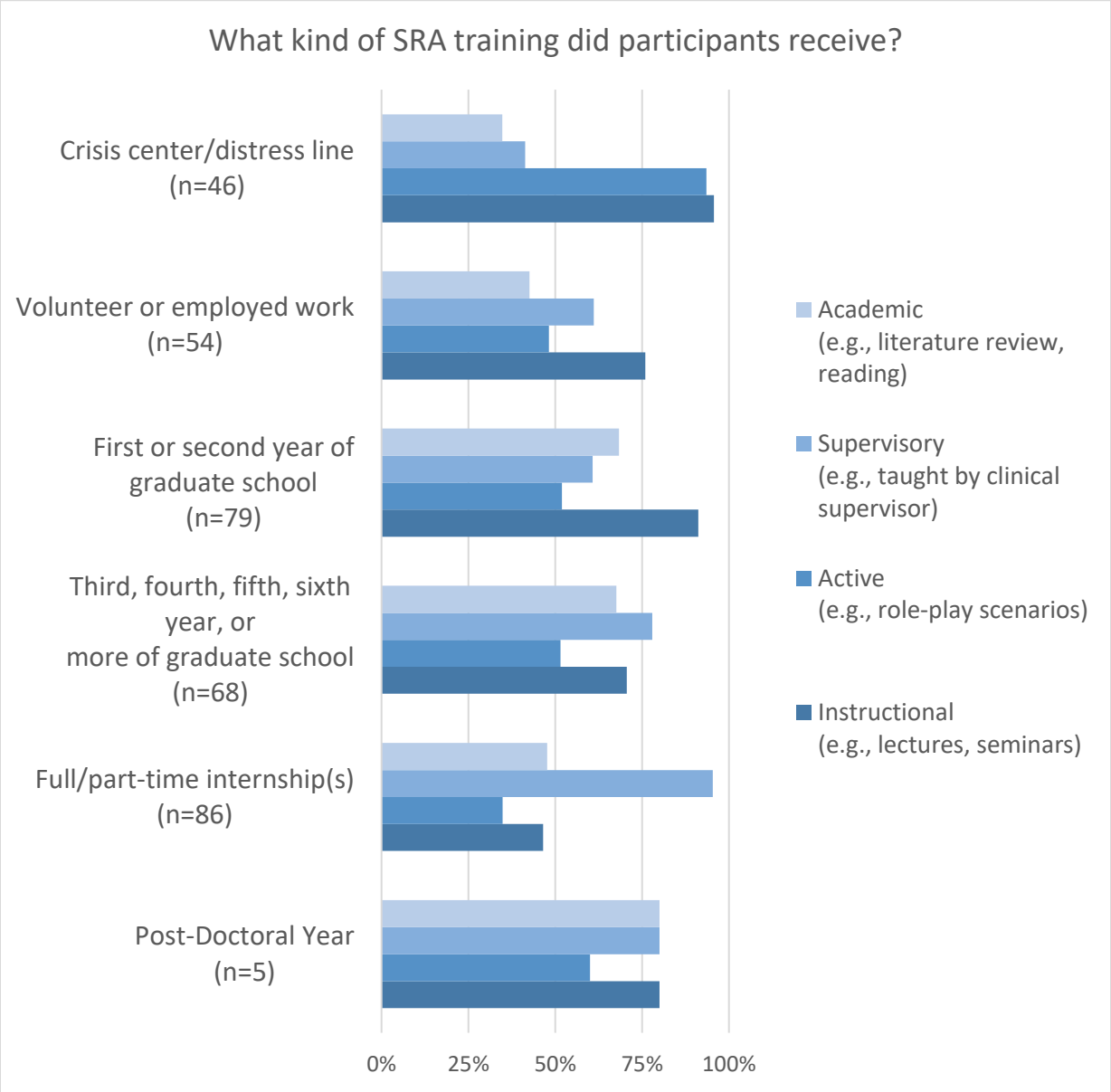


Figure 14

What Kind of Professional Development, Workshops, or Continuing Education Did Participants Complete?

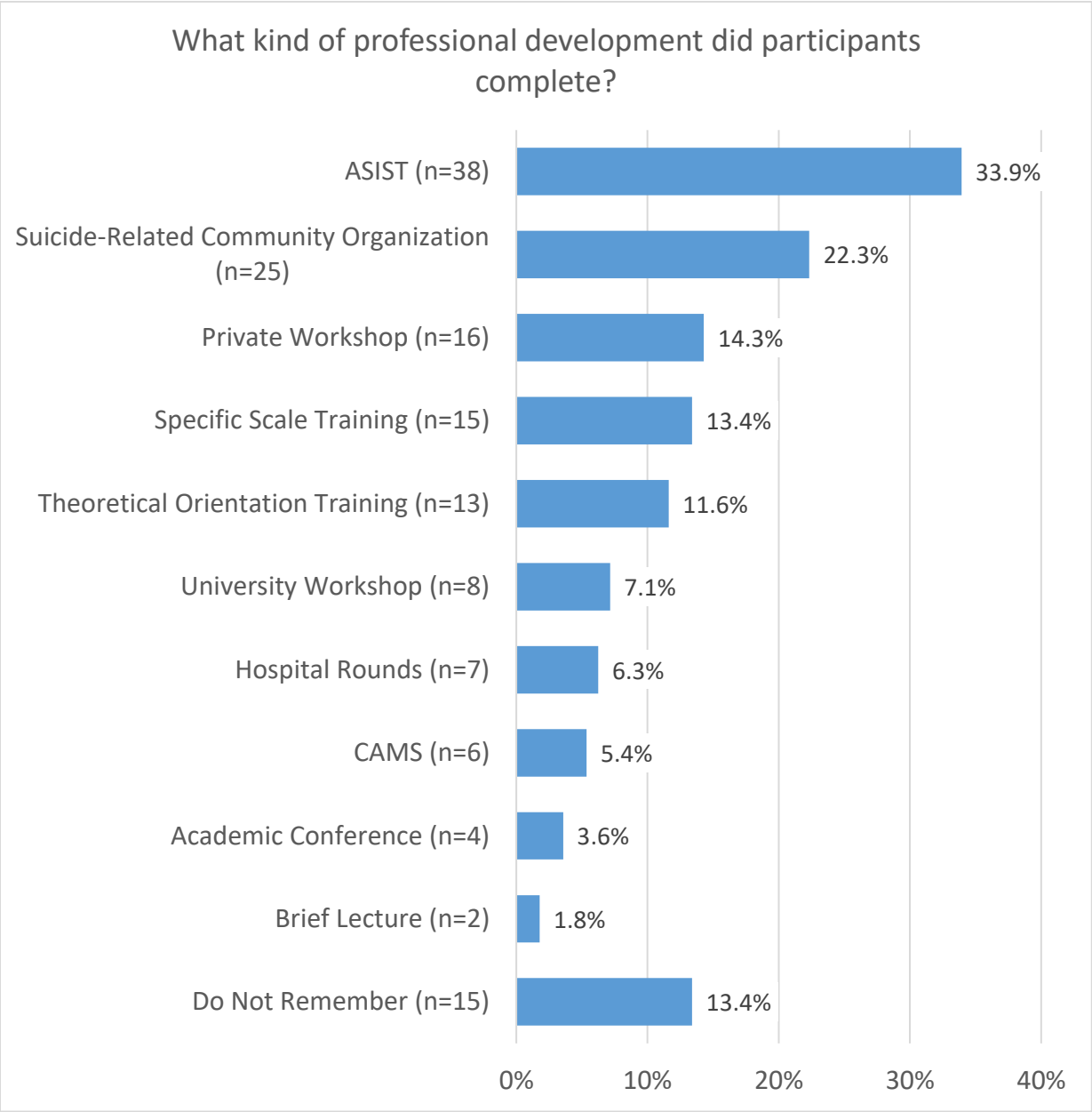


Figure 15

What Kind of Self-Directed or Informal Learning Did Participants Complete?

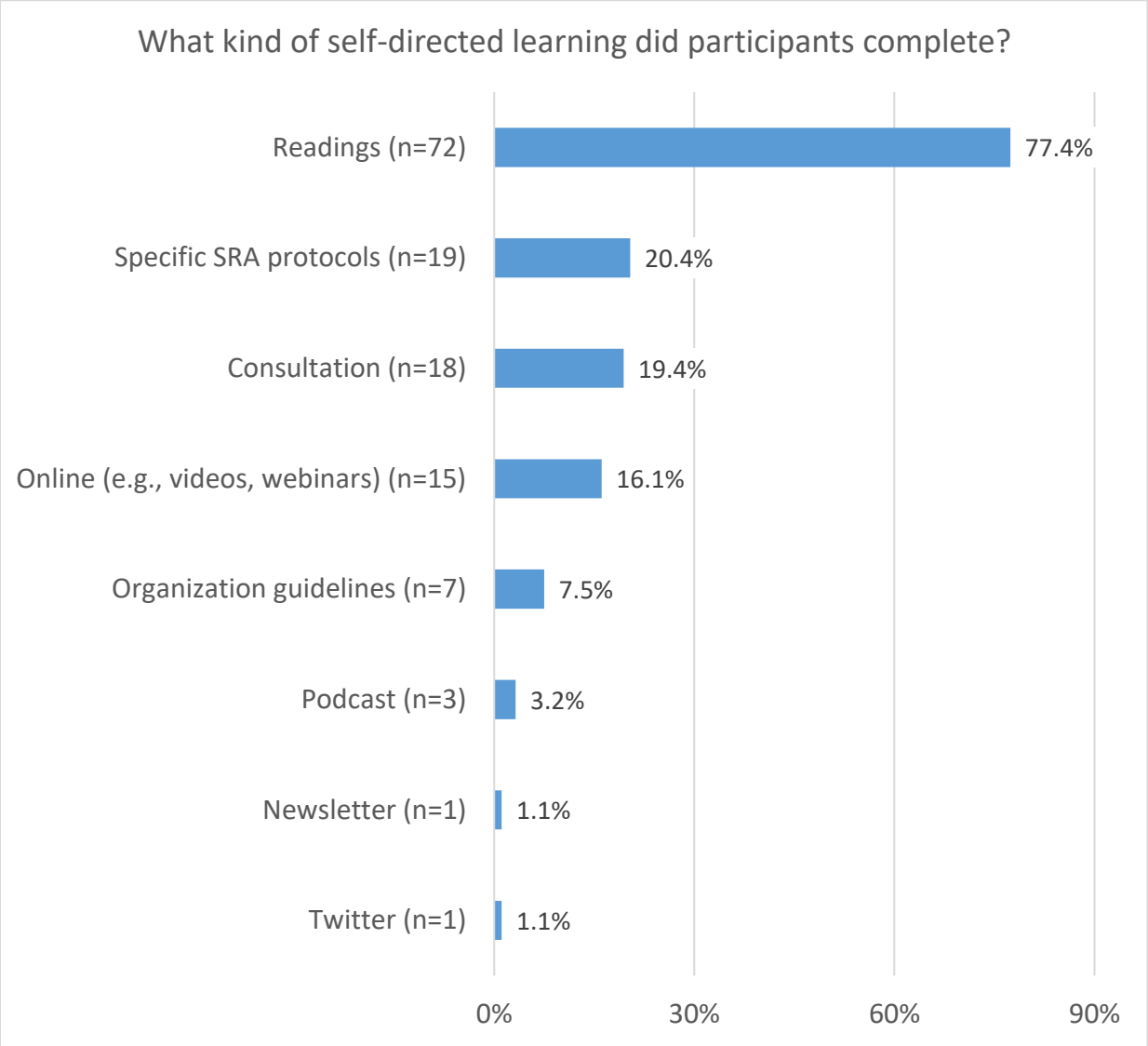


Figure 16

What Made Participants Pursue Professional Development or Self-Directed Learning?

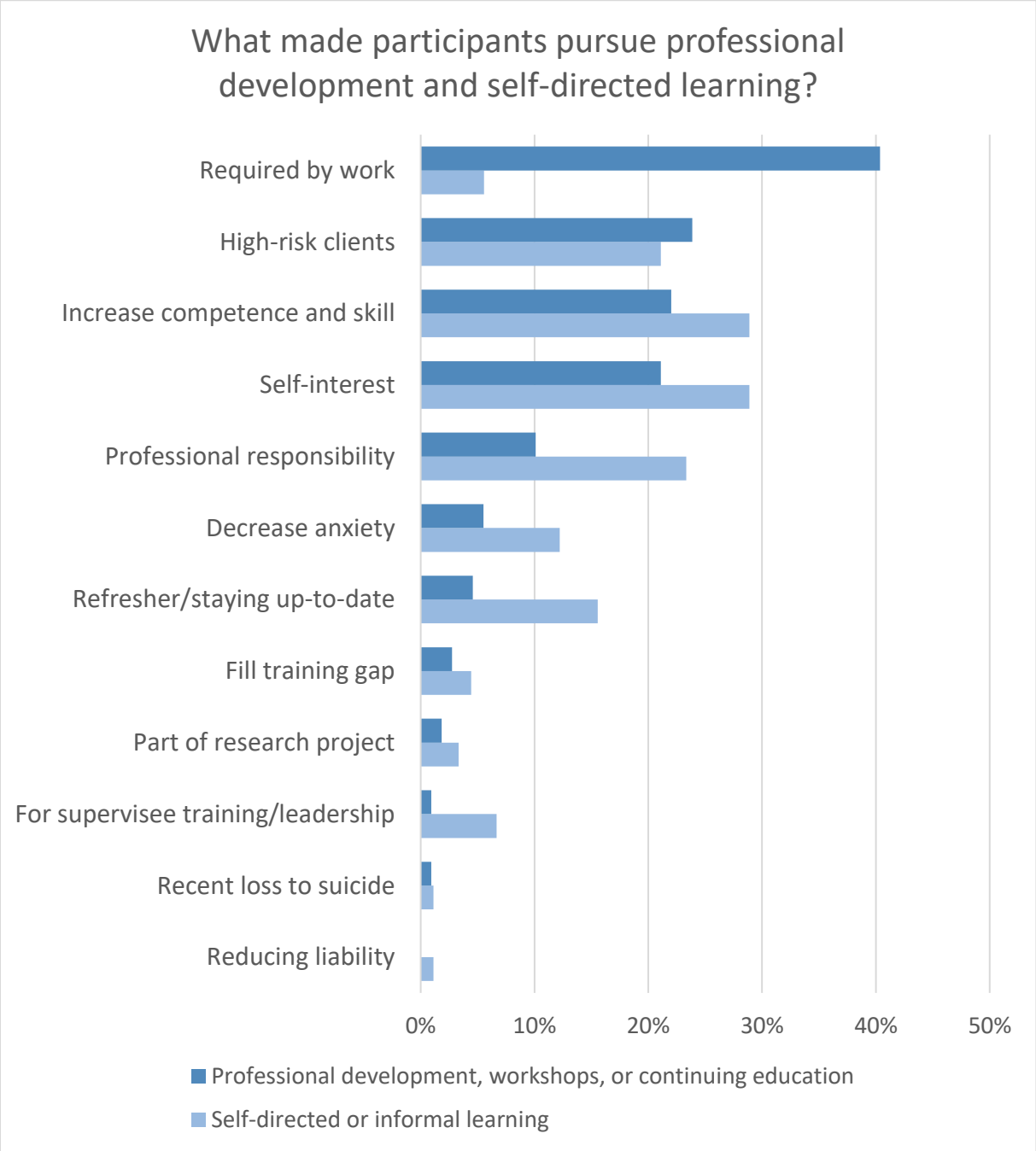


Figure 17

Which Training Influenced Participants' SRA Practice the Most?

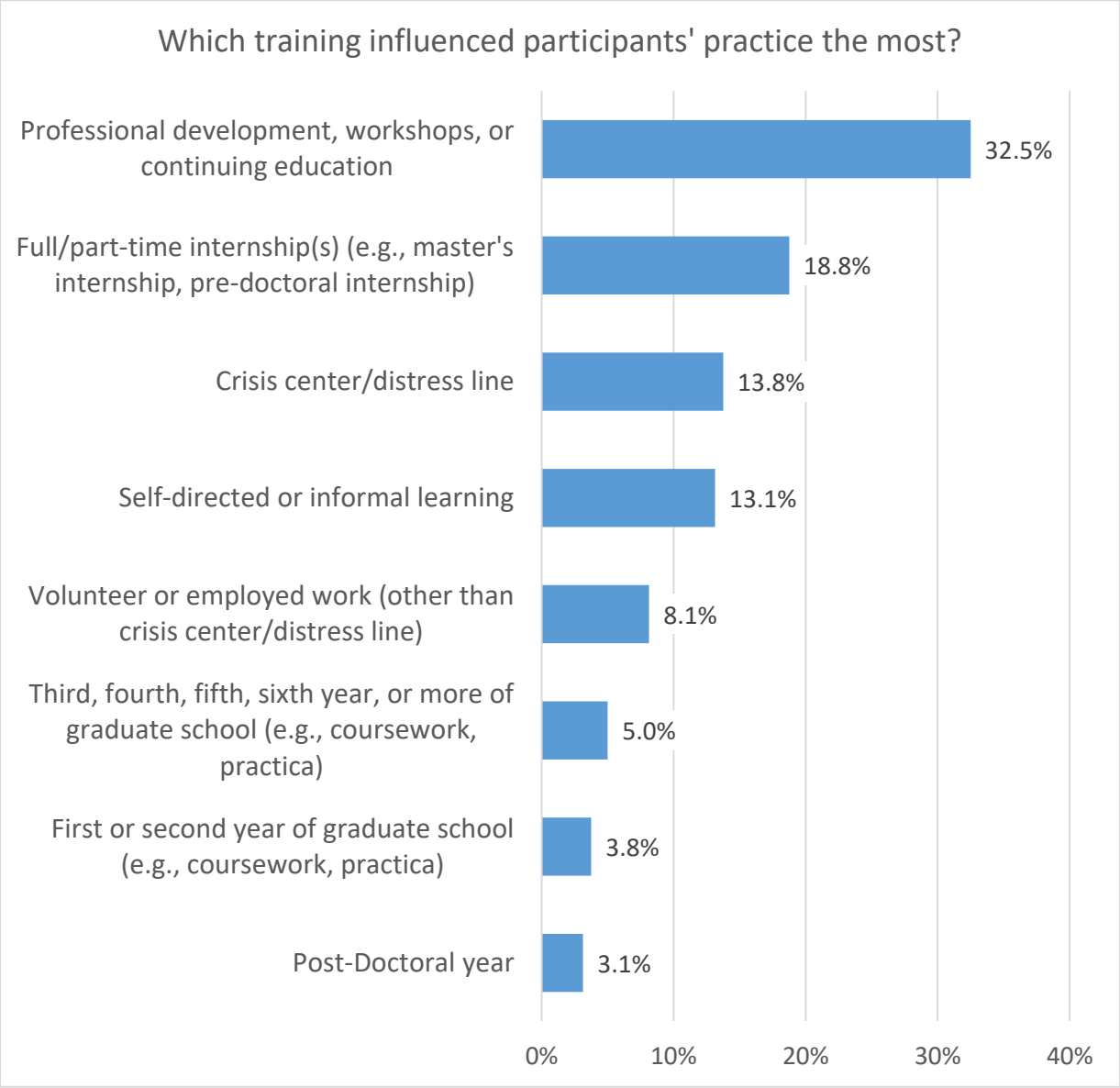
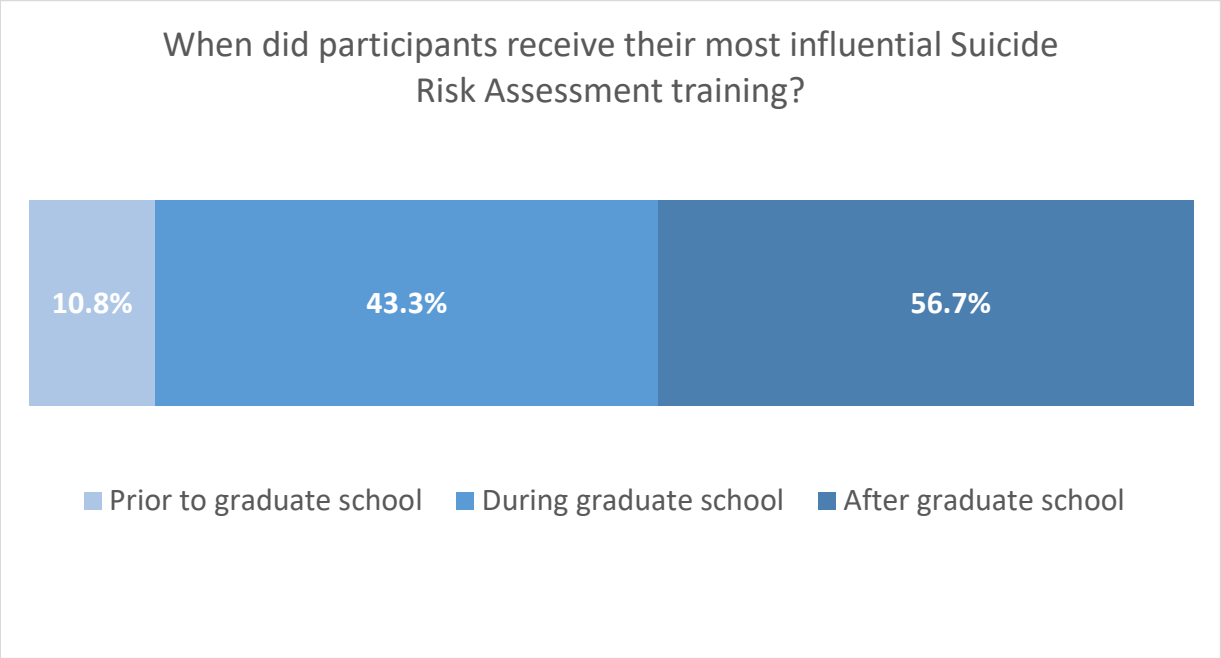


Figure 18

When Did Participants Receive Their Most Influential SRA Training?



Note. Participants could endorse more than one option. Total responses equal 110.8%

Figure 19

What Made Participants' Influential Training Influential?

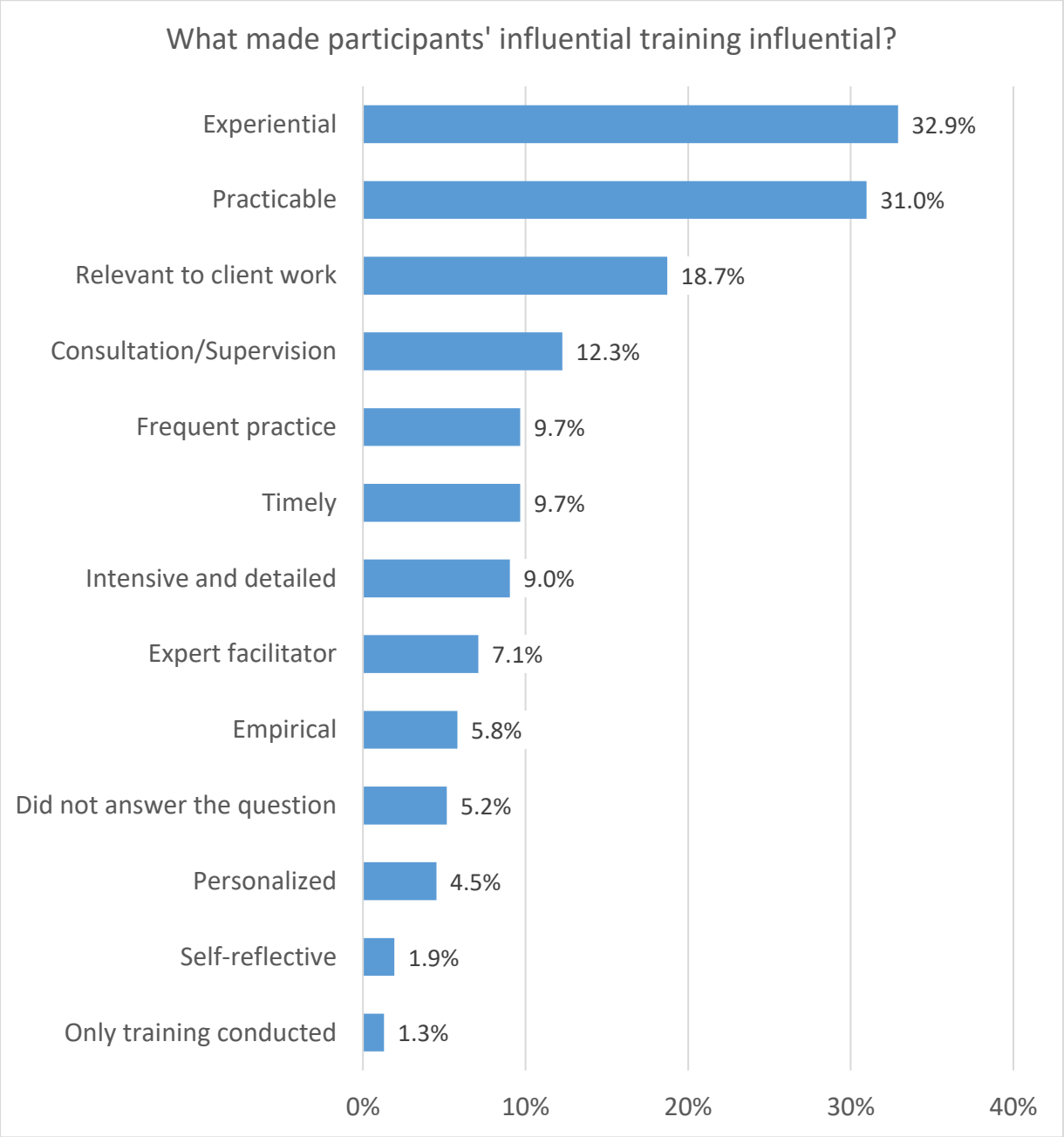


Figure 20

Participants' SRA Training Experiences

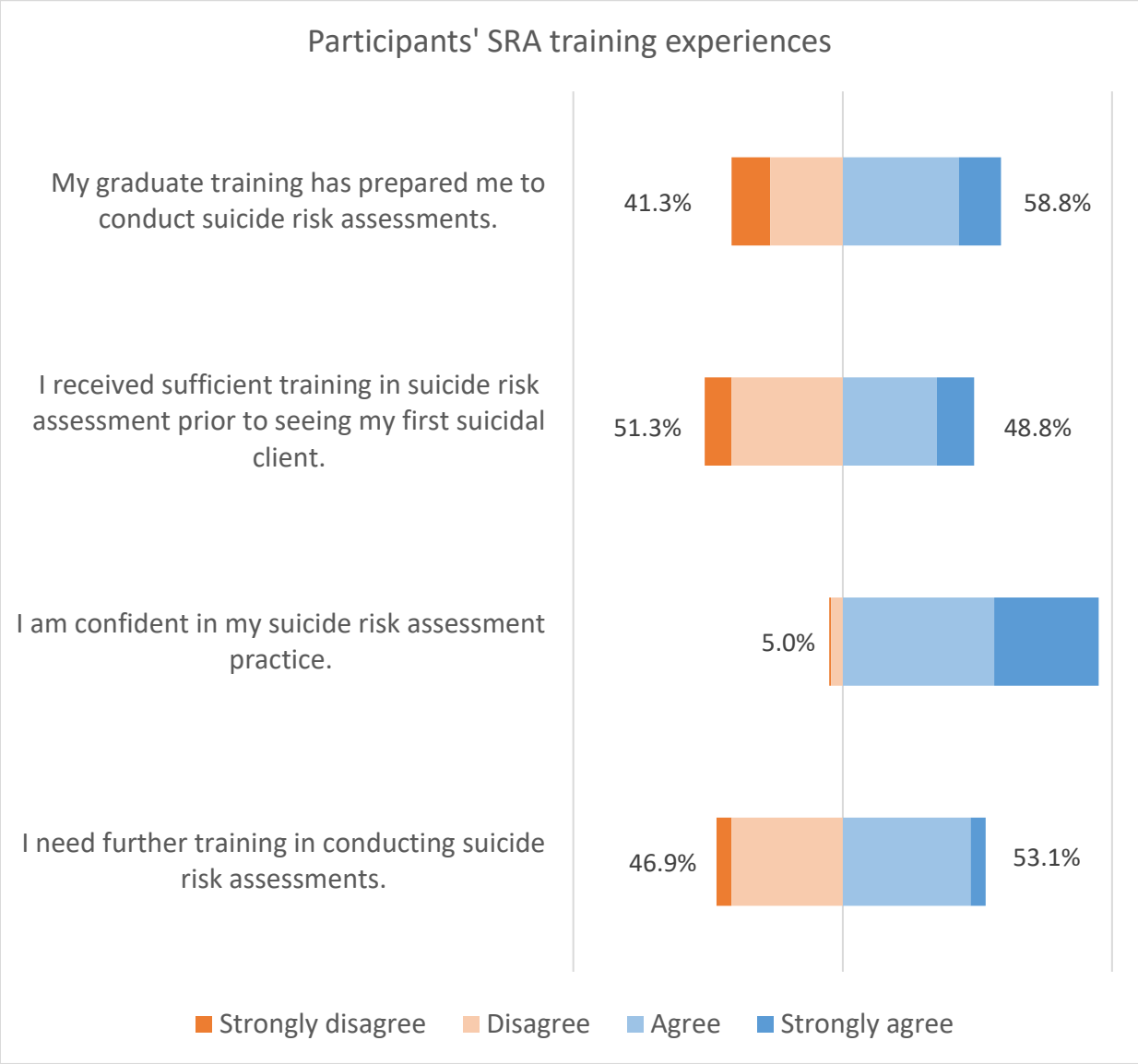
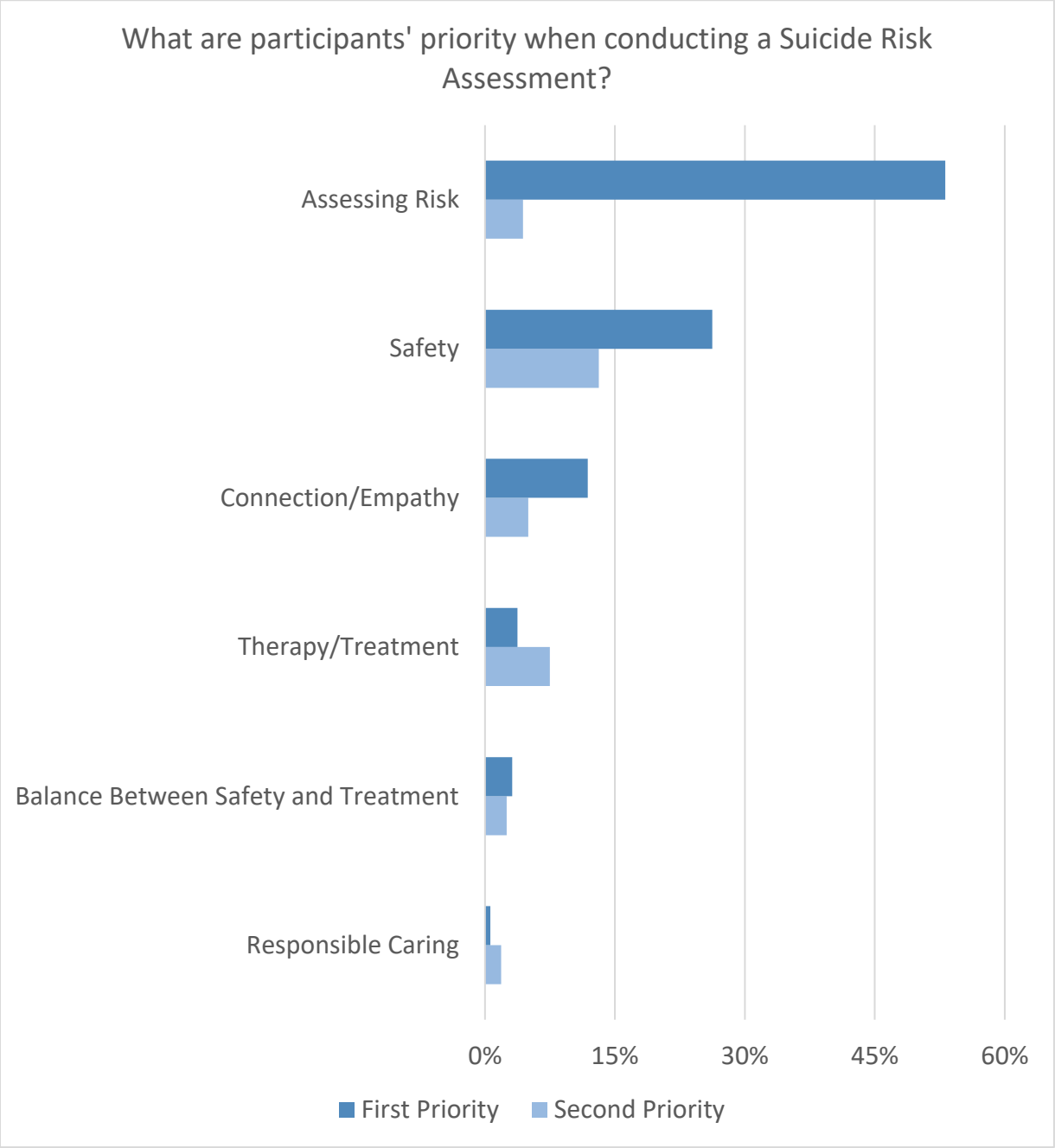


Figure 21

What Are Participants' Priorities When Conducting an SRA?



Note. 1.3% of participants did not report any priority and 34.4% reported a second priority.

Figure 22

Participants' SRA Experiences: Relying on Clinical Intuition

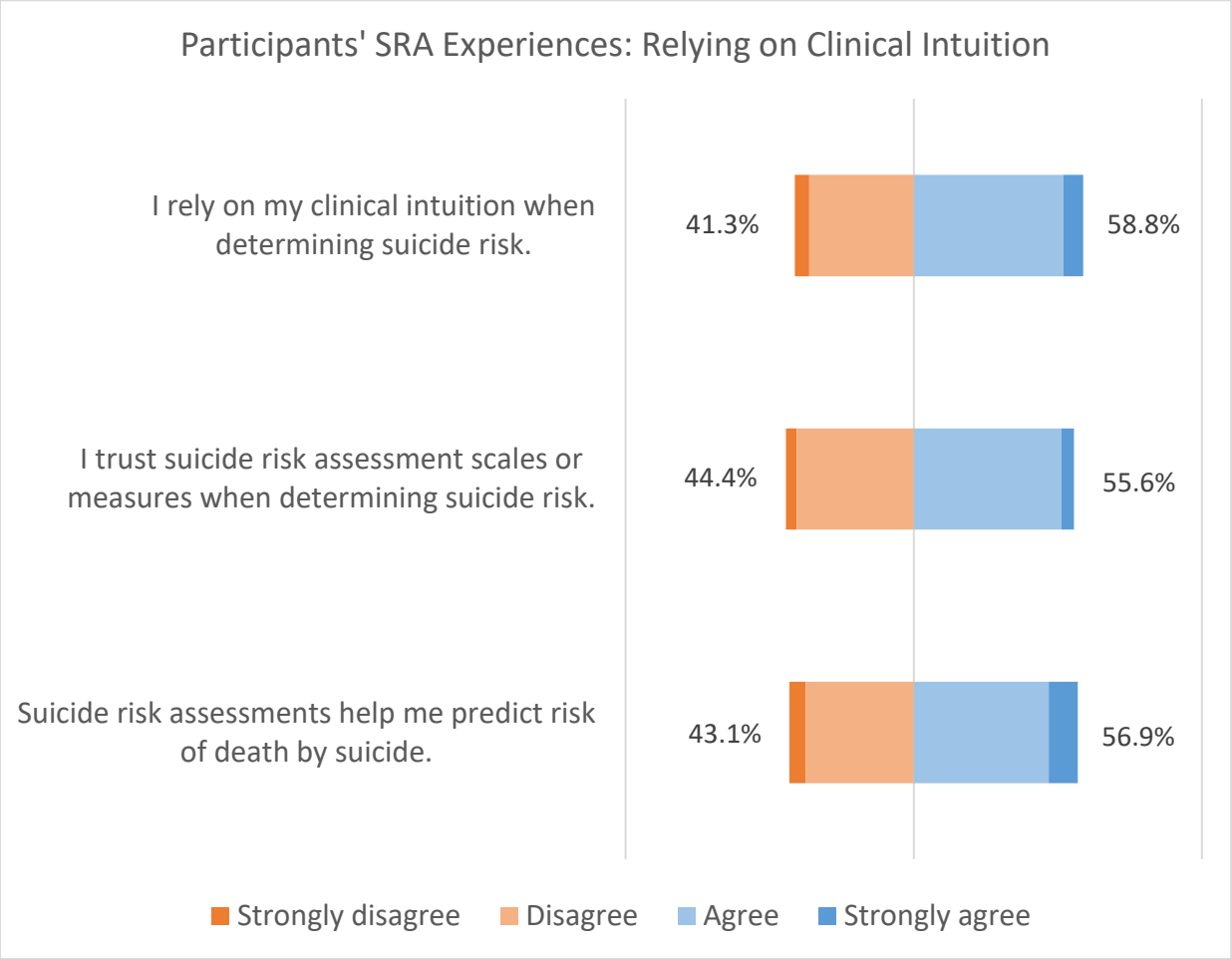


Figure 23

Participants' SRA Experiences: Relying on Clinical Intuition (cont.)

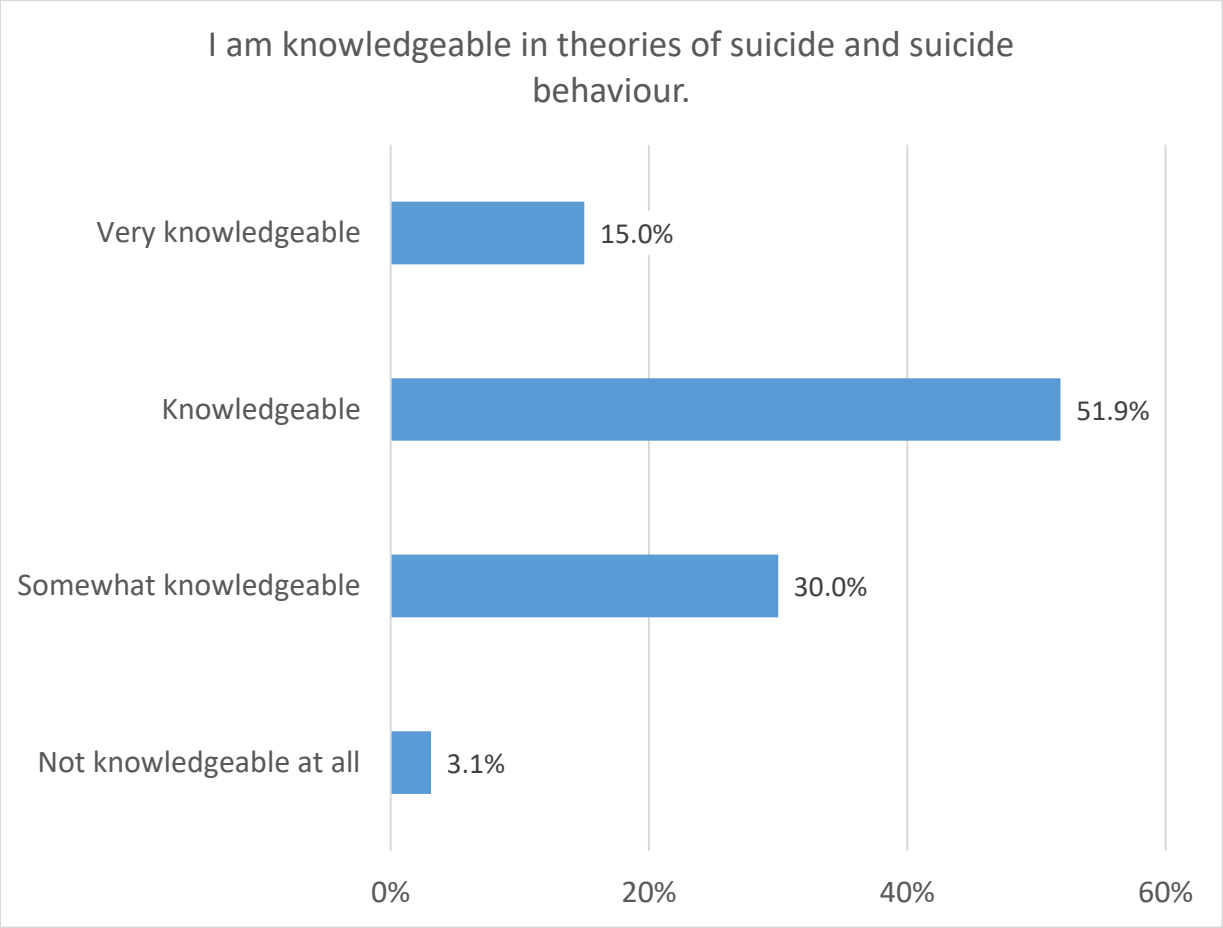


Figure 24

Participants' SRA Experiences: Investing in the Suicidal Client

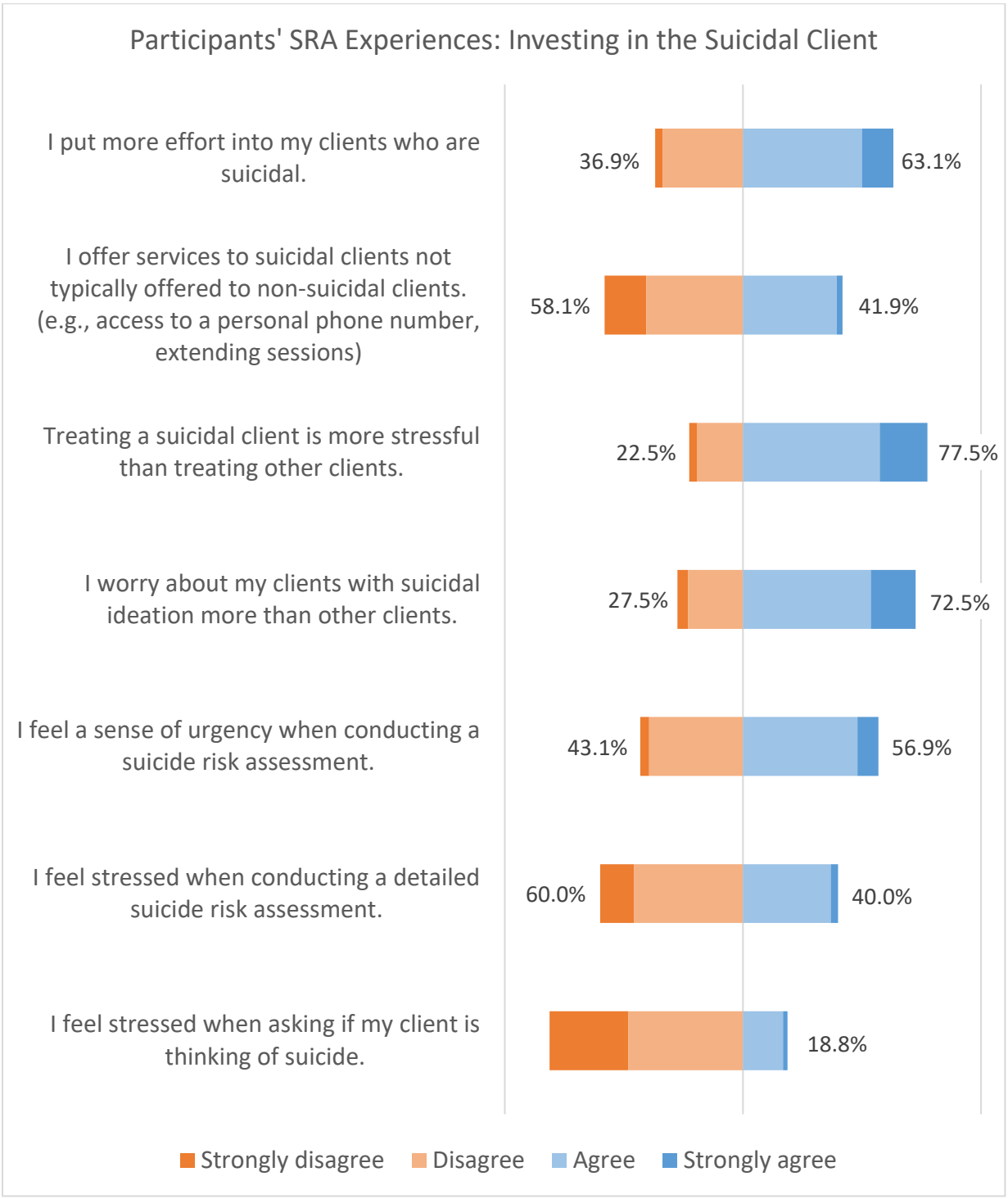


Figure 25

Participants' SRA Experiences: Investing in the Suicidal Client (cont.)

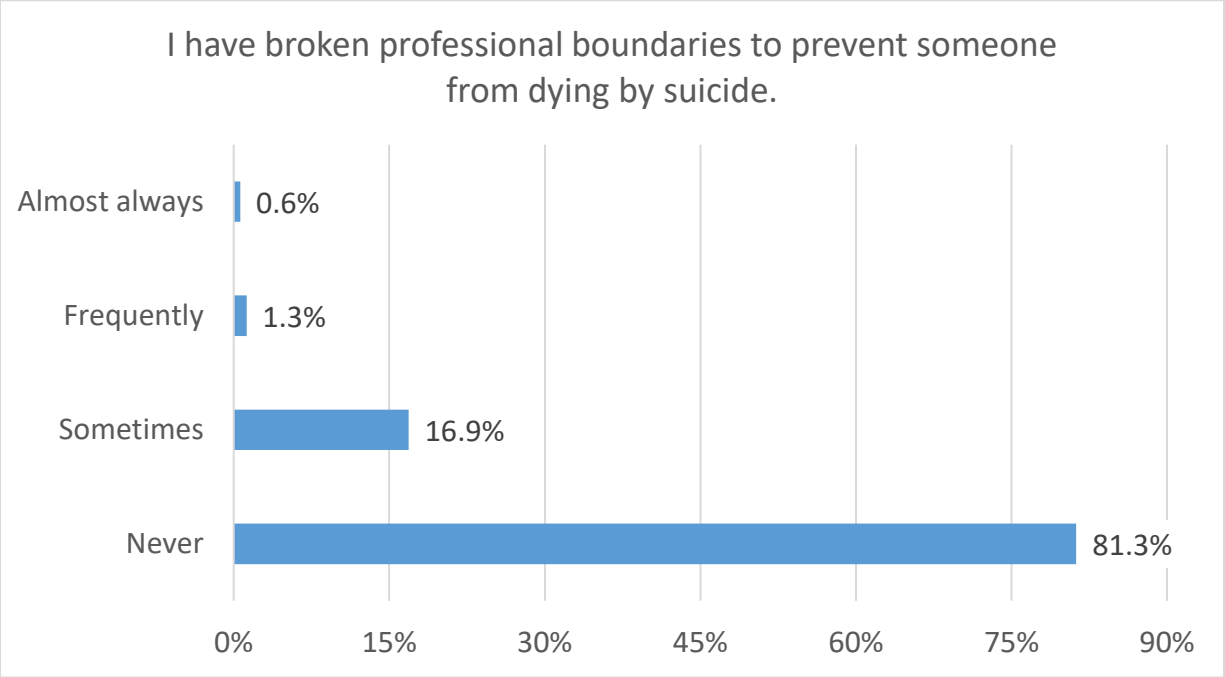


Figure 26

Participants' SRA Experiences: Fear of Client Suicide Drives SRA

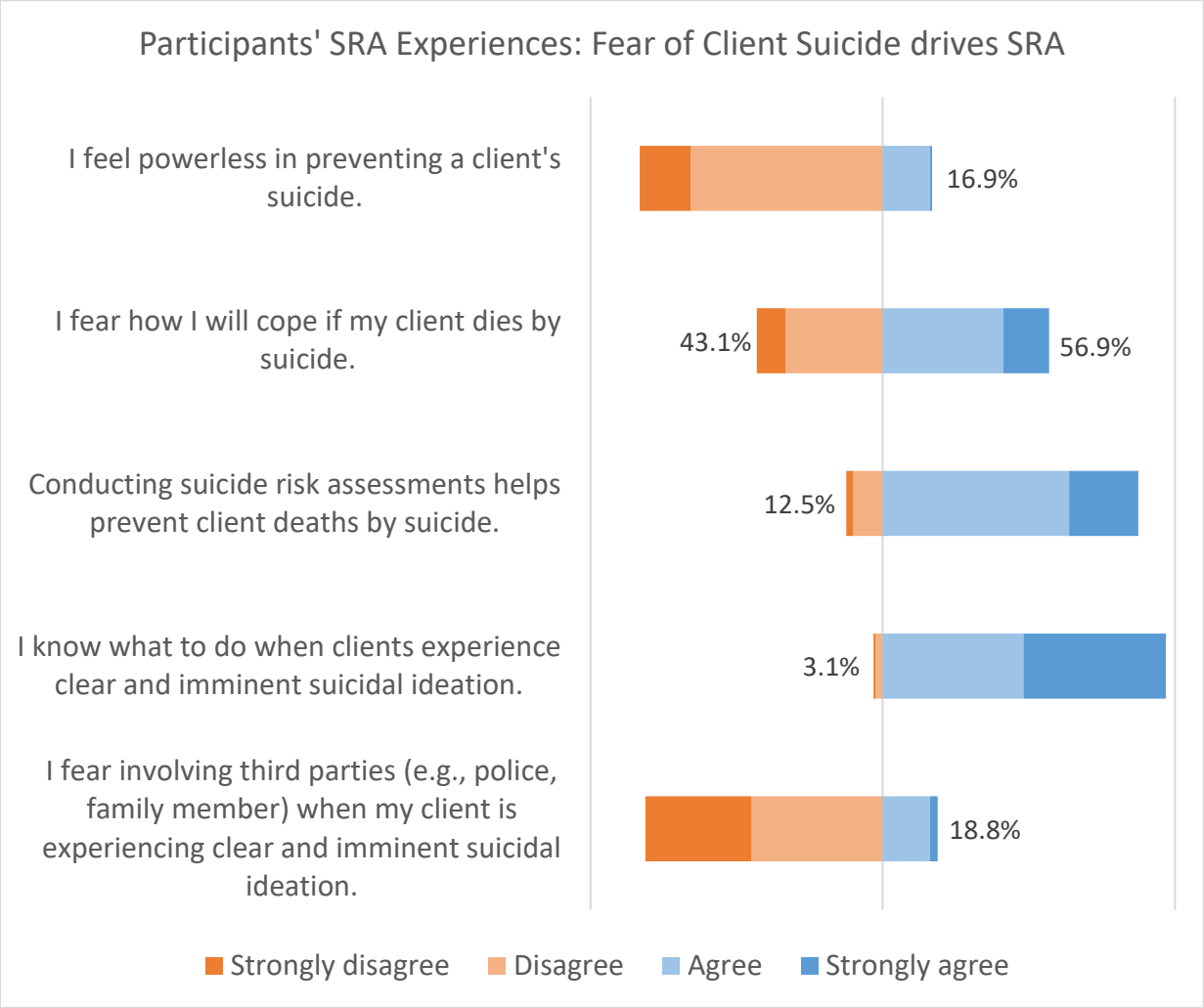
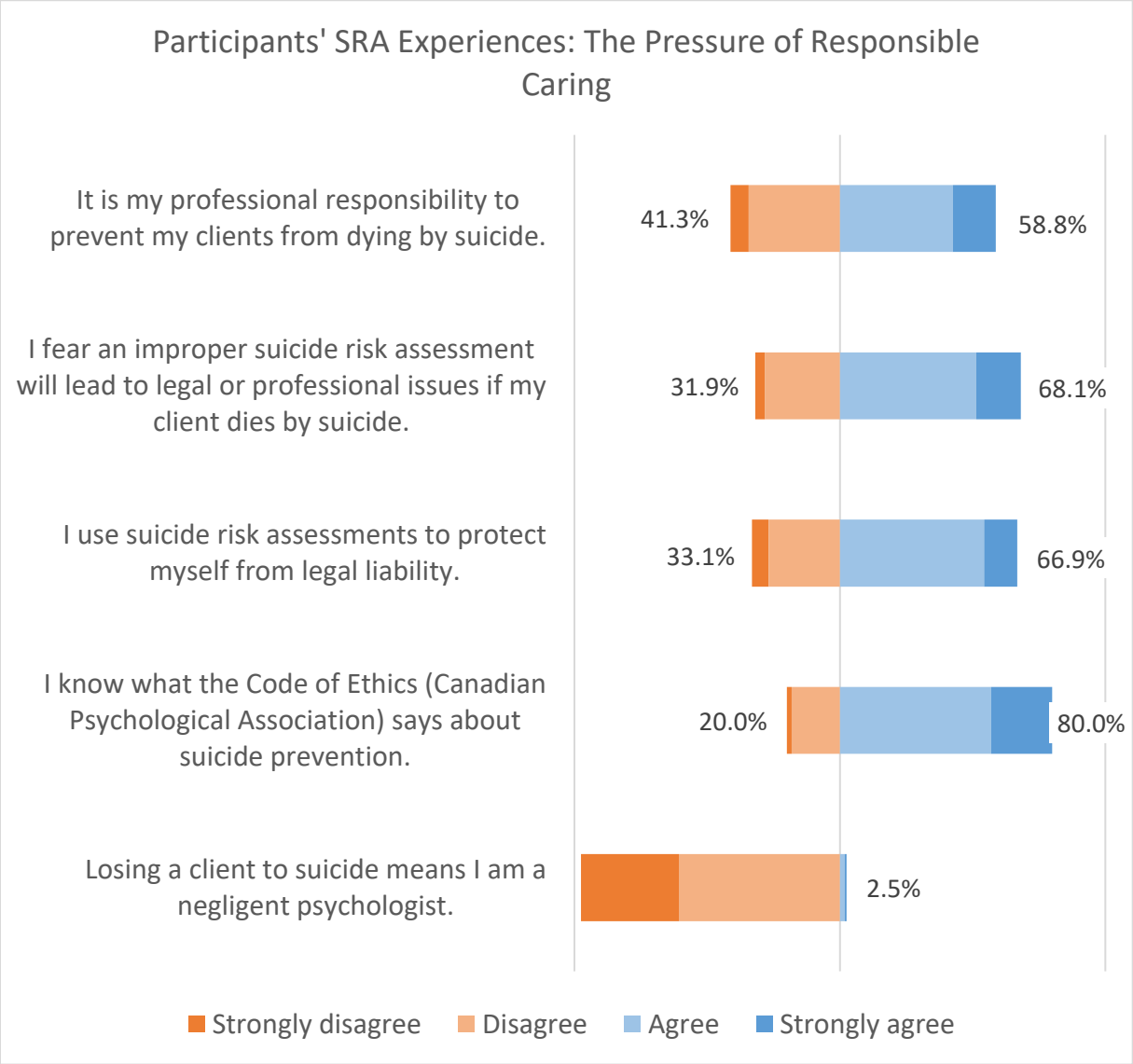


Figure 27

Participants' SRA Experiences: The Pressure of Responsible Caring



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Appendix 1 – Survey Development Process

The development of the survey underwent multiple stages: (a) original item development and adaptations, (b) expert and peer review, (c) pilot study, (d) think-alouds, and (d) final expert review (see below for an illustrated version of the survey development process).

The development of the survey began with my supervisor and I deciding to explore and understand psychologists' SRA experience through Interpretative Phenomenological Analysis (J. A. Smith et al., 2009). I then developed a 40-item scale measuring psychologists' SRA Attitudes and Practices that had a mix of original items and items from suicide attitude scales, such as the Attitudes Towards Suicide Scale (Cwik et al., 2017). The items were written using the survey design principles described in Creswell (2015). Insights from my qualitative study (Dubue & Hanson, 2020), my 40-item scale, and items adapted from other studies (see Appendix 2) informed the development of the SRA Practices, Training, and Experiences Survey. Prior to expert and peer review, I wrote a short rationale for each item that included empirical backing, or the modifications made from existing scales/items (see Appendix 2).

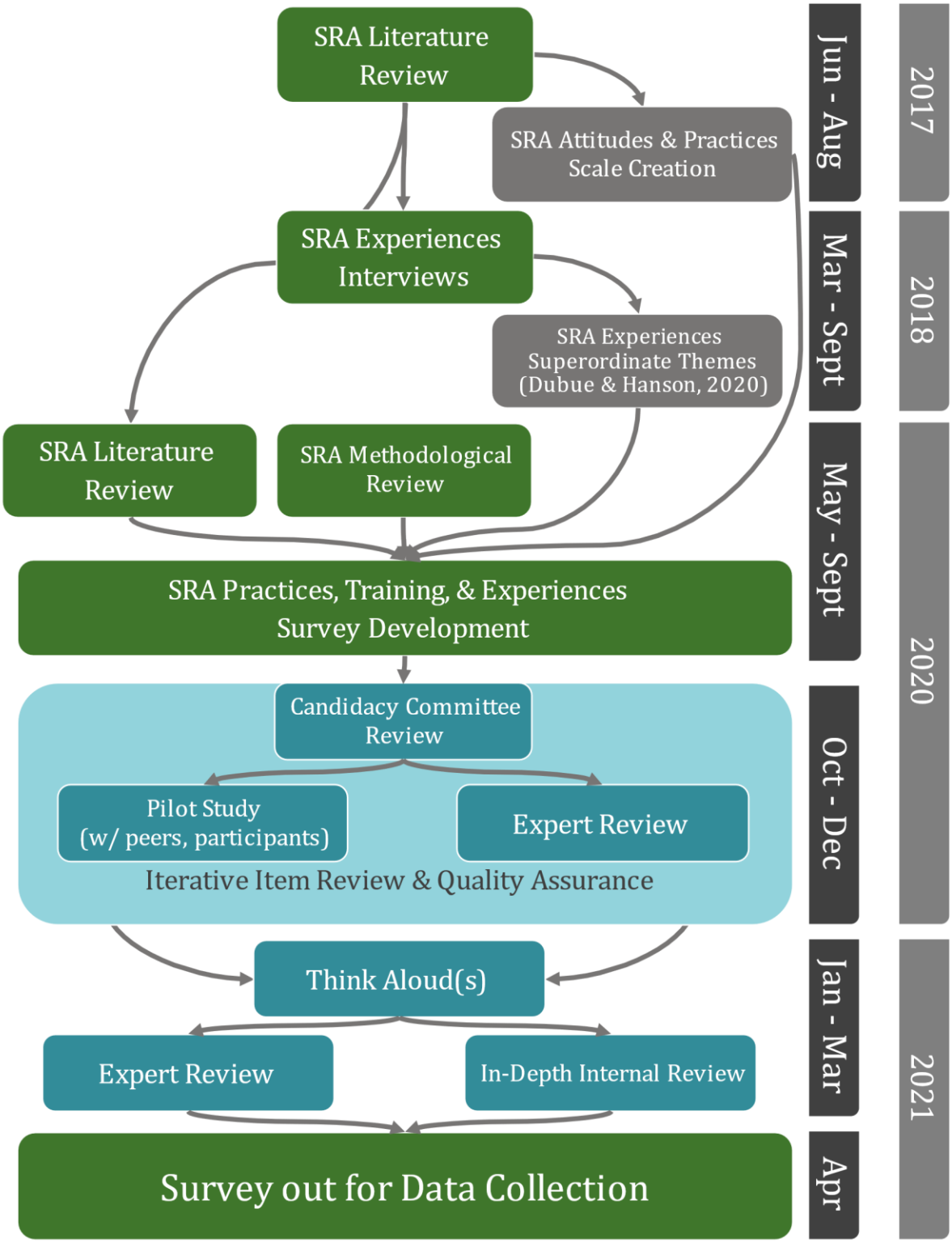
From October to December 2020, the survey was reviewed by my dissertation committee and experts in suicide prevention. I received and implemented suggestions regarding item clarity (e.g., defining legal liability, clarifying constructs being measured) and what additional items could be included.

Concurrent with the first expert review, I piloted the survey with 30 participants who were either Ph.D. students in professional psychology programs or Registered Psychologists in Canada. These participants were recruited through convenience and snowball sampling and were not representative of Psychologists in Canada. Most were from Alberta (93.8%), female (60.0%), had received a Master of Education (60.0%), and personally knew me. Although this sampling incurred immense bias in data interpretation, it was still appropriate given my intention was to screen for ceiling and floor effects and receive general feedback on the survey completion experience (e.g., timing, flow, understanding of

items). The pilot survey participants completed a five-question open-ended feedback questionnaire asking about (a) the clarity and coverage of the items, (b) the survey flow, (c) the accessibility of the survey, (d) the timing of the survey, and (e) any other relevant feedback. From this feedback, I implemented multiple changes to make the survey easier to complete (e.g., decreasing the number of items per page), changed the response set on multiple questions, and revised item wording for clarity. Changes were also made in response to feedback and learnings received during a graduate-level survey design course that I took concurrently with the survey's development.

From January to March 2021, I conducted three think-alouds using Trenor and colleagues' (2011) protocol (see below). Think-alouds are cognitive interviews where participants are asked to explain their thinking on each survey question (Willis, 2004). In this way, survey developers assess if participants have an appropriate understanding of the question, and that their cognitive process is consistent with the desired intent (Trenor et al., 2011). Participants were purposefully heterogenous and included a registered psychologist, a graduate student in the field of education, and an allied health professional with limited SRA experience. The think-alouds took between 45 minutes to 1.5 hours, and the allied health professional and registered psychologist continued to provide feedback after their interviews were completed. Here, each item was reviewed in concert with the development rationale to promote face validity. Through this process, nearly every item was modified. Some items had simple syntax changes whereas others were overhauled to better describe the intended construct.

Lastly, prior to data collection, the survey was once more reviewed by experts in suicide prevention and survey design. All three experts took the survey and offered minor feedback on item clarification.


SRA Literature Review
SRA Attitudes & Practices Scale Creation
SRA Experiences Interviews
SRA Experiences Superordinate Themes (Dubue & Hanson, 2020)
SRA Literature Review
SRA Methodological Review
SRA Practices, Training, & Experiences Survey Development
Candidacy Committee Review
Pilot Study (w/ peers, participants)
Expert Review
Iterative Item Review & Quality Assurance
Think Aloud(s)
Expert Review
In-Depth Internal Review
Survey out for Data Collection
Jun - Aug
Mar - Sept
May - Sept
Oct - Dec
Jan - Mar
Apr
2017
2018
2020
2021

THINK-ALOUD PROTOCOL

Based on Trenor, Miller, and Gipson (2011)

Process

- Tell the respondent to voice any confusion or trouble he/she has when taking the survey.
- Make sure the respondent is aware that the purpose of the study is to evaluate the *survey*, not the respondent's performance. Treat the respondent as more of a 'partner' in the study.
- If the respondent seems to be struggling with a particular question, probe with a question to help fully understand the thought processes going through the respondent's mind.

Potential Probing Questions

1. What do you think this question is asking you?
2. How do you think you should answer this question?
3. Is this question confusing? *(Avoid asking if the respondent is confused.)*
    - If so, what would make this question less confusing?
4. What are you thinking about?
5. How did you arrive at that answer?
6. What does (a particular word/concept) mean to you?

As researchers, we should consider the following questions if it is unclear whether a respondent is having an issue:

- Does the respondent have an accurate internal representation of each question?
- Does the respondent have to re-read questions?
- Does the respondent seem to be giving a complete answer?

Utilize *respective protocol*, where at the end of the survey (or at logical midpoints), the respondent will be asked to reflect upon the questions encountered and responses provided to determine if, after looking back, anything else seems confusing or if there is any additional information the respondent thinks we should know but the instrument has not sufficiently drawn out of the respondent.

Appendix 2 – SRA Practices, Training, and Experiences Survey with Item Rationale

Psychologists' Suicide Risk Assessment Practices and Experiences in Canada

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SURVEY START

Thank you for your interest in our survey exploring psychologists' suicide risk assessment practices and experiences!

The purpose of this survey is to better understand how psychologists conduct suicide risk assessments and how the practice affects them. The goal is to use these data to inform suicide risk assessment training, practice, and policy in Canada.

The survey should take 20-30 minutes to complete.

The survey is anonymous, and you can exit at any time.

The plan for this study has been reviewed by a Research Ethics Board at the University of Alberta (Pro00105480). If you have questions about your rights or how research should be conducted, you can call (780) 492-2615. This office is independent of the researchers.

The full Information Letter and Consent Form can be found here: bit.ly/SRASurveyConsent

If you have any further questions, please contact Jonathan Dubue (jdubue@ualberta.ca).

Thank you for your time!

Sincerely,

Principal Investigator:
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Co-Supervisor:
William Hanson, Ph.D.
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- I agree to participate in the research study described above. I have read and understood the consent form (bit.ly/SRASurveyConsent) and desire of my own free will to participate.
- I do not consent to participating in this study.

Section 1: Inclusion Criteria

Section Introduction

Okay! Let's get started.

This should take 20-30 minutes or less.

First, let's make sure you're a good fit for this survey.

---

1. I am a registered or licensed psychologist currently practicing in Canada in good standing with my provincial accrediting body.
   - Yes
   - No
2. I have conducted suicide risk assessments* with clients/patients within the last 10 years.
   *the act of discussing, determining, or monitoring a person's risk of dying by suicide.
   - Yes
   - No

If either answer is "no," the participant is moved to a separate page reading:

To be included in this study you **must** be a registered psychologist in Canada in good standing with your provincial accrediting body **AND** have conducted suicide risk assessments with clients/patients within the last 10 years.

If you made an error on the inclusion criteria questions and actually do meet the above criteria, please return to the previous page by click on the "back" button, located below.

If you do not meet criteria, we thank you sincerely for your time and consideration! You may now close this survey.

If both answers are "yes," the participant is moved to a separate page with the following questions:

3. Approximately, when did you last conduct a suicide risk assessment?
   - In the past 7 days
   - In the last month
   - In the last 6 months
   - In the last year
   - In the last 5 years
   - In the last 10 years
4. How interested are you in the study and practice of suicide risk assessment?
   - Extremely interested
   - Very interested
   - Moderately interested
   - Slightly interested
   - Not at all interested

Section 2: Practices

Section Introduction

Excellent. Now, let's talk suicide risk assessment practices.

The next few questions are important. Please take your time with this section.

---

5. How often do you use suicide risk assessments?
   - Rarely (with a small percentage of clients)
   - Sometimes
   - Frequently
   - Almost Always (with a large percentage of clients)
6. On first visits with new clients, how often do you assess for suicide risk?
   - Rarely (with a small percentage of clients)
   - Sometimes
   - Frequently
   - Almost Always (with a large percentage of clients)
7. In a one-on-one psychotherapy session, a client tells you they are thinking of dying by suicide.

   Step-by-step, what do you do?

   Please describe your process in full.
   This is the biggest question of the survey.
   You may use bullet points if preferred.

   Open-ended long answer response.

Section Item Development/Analysis Rationale

Section 1: Practices *This section broadly examines how psychologists practice suicide risk assessment and how often they do so. The open-ended question in this section is the biggest of the survey. I've developed an analysis checklist for the answers (see the last page of this document), and they will be analyzed by both myself and a Ph.D. student/collaborator.*	
Item	**Purpose and Item Development Rational**
How often do you use suicide risk assessments?	Assesses frequency of SRA use. Note: This item assesses a *proportion* of psychologists' SRA practice, rather than actuarial frequency. This is easier to answer, rather than ask participants to (a) list how many clients they see in an arbitrary timeframe and (b) estimate the amount of SRAs they conduct on that sample.

On first visits with new clients, how often do you assess for suicide risk?	Supplements the previous question to determine the rationale and usage frequency of SRA. The response scale was developed from previous literature (Higgins et al., 2016).
In a one-on-one psychotherapy session, a client tells you they are thinking of dying by suicide. **Step-by-step, what do you do?** *Please describe your process in full. This is the biggest question of the survey. You may use bullet points if preferred.*	I elected for an open-ended response format to: (a) decrease the number of items, (b) decrease the risk of social desirability bias, and (c) better simulate an actuarial SRA. Notably, checklists have been used in previous research to determine SRA practices (at least twice). To my knowledge, this is the first time SRA practices will be measured using an open-ended survey question.

Section 3: Training

Section Introduction

Great! Thanks for helping us understand more about your suicide risk assessment practices.

Now, let's talk about your training.

---

1. Have you received training* in suicide risk assessment?
   *Training, in this study, is learning from someone who has knowledge or skill related to the topic.
   a. Yes
   b. No
2. If so, where did you receive training?
   (Select all that apply)
   a. Crisis center/distress line
   b. Volunteer or employed work (other than crisis center/distress line)
   c. First or second year of graduate school (e.g., coursework, practica)
   d. Third, fourth, fifth, sixth year, or more of graduate school (e.g., coursework, practica)
   e. Full/part-time internship(s) (e.g., master's internship, pre-doctoral internship)
   f. Professional development, workshops, or continuing education
   g. Self-directed or informal learning
   h. Other:_____
   i. None of the above (I did not receive training in suicide risk assessment)
      i. If selected, move the participant to question 9 of this block.

--page break--

3. What kind of training did you receive at [each individually endorsed location]
   a. Instructional (e.g., lectures, seminars)
   b. Active (e.g., role-play scenarios)
   c. Supervisory (e.g., taught by clinical supervisor)
   d. Academic (e.g., literature review, reading)
   e. Need to say more? _____
4. ***If "Professional development, workshops, or continuing education" was endorsed:*** Regarding professional development, workshops, or continuing education:
   a. Which training(s) did you complete? _____
   b. What made you pursue these training(s)? _____
5. ***If "Self-directed or informal learning" was endorsed:***
   Regarding self-directed or informal learning:
   a. What kind of self-directed or informal learning did you complete?
      _____

b. What made you pursue self-directed or informal learning? _____

--page break--

6. Which training influenced your suicide risk assessment practice **the most**?
   [Only options endorsed from Q2 will be shown here]
7. (If any option other than c, d, or e) When did you receive this training?
   a. Prior to graduate school
   b. During graduate school
   c. After graduate school
8. What was it about this training (endorsed option from Q5 here) that made it **the most** influential?
   Please be brief with your answer (1-2 sentences).
   a. Open-ended short-answer _____

To what extent do you agree with the following statements:
(Strongly Disagree, Disagree, Agree, Strongly Agree)

9. My graduate training has prepared me to conduct suicide risk assessments.
10. I received sufficient training in suicide risk assessment prior to seeing my first suicidal client.
11. I am confident in my suicide risk assessment practice.
12. I need further training in conducting suicide risk assessments.

Section Item Development/Analysis Rationale

Section 2: Training *This section explores psychologists' suicide risk assessment training. Particularly, it assesses (a) if they got trained, (b) where they got trained, (c) how they got trained, (d) what was important to them in their training, and (e) how well their training prepared them/made them feel confident in practicing SRAs.* *The formal definition for training used in this study is: "Training is a discrete learning experience designed to engender change in an individual's knowledge, attitudes, and/or skills and is typically provided by an individual(s) who is assumed to have the requisite knowledge in said learning area" (as cited by* (Monahan, 2018) *from Campbell et al. (1970).* *Notably, this section **does not** assess suicide risk assessment competency.*	
Have you received training in suicide risk assessment?	Assesses presence of previous training. Dexter-Mazza and Freeman (2003) found fewer than 50% of psychology trainees have received suicide risk assessment training, with over 30% of mental health professionals believing they have received insufficient suicide-focused training (Jahn et al., 2016).
If so, where did you receive training? *(Select all that apply)*	Assesses location/setting of training. The response scale mimics that of Kerr (2019). It has been expanded to include more options. This question is important to determine to what degree psychologists are being trained during graduate studies, and if not, where else. If the participant has not completed any SRA training, they will redundantly indicate it twice (once in this question and the one prior). Pilot test data suggested some participants did not understand what was meant by "training" and incorrectly answered "no". This way, participants will review the list of training and confirm whether or not they truly did not

	receive any SRA training. If they answer "none of the above" here, they will be moved to the Training Preparedness question (question 9 of this block).
What kind of training did you receive at [each individually endorsed location]	If a location/setting is endorsed, this question will further elucidate what *kind* of training. This is important as suicide risk assessment training may be better integrated into practice if it extends beyond lectures (McNiel et al., 2008). Specifically assesses the presence of active (e.g., role-plays) vs passive (e.g., lectures) learning. The former is suggested as being better for learning suicide risk assessments (Monahan, 2018).
If "professional development" or "self-directed learning" was endorsed: Regarding [that training] training/professional development:	Answers to this question will offer an estimate of how much time and effort is spent being trained outside their institution, and why folks chose additional training. This would help inform the need and/or desire for SRA training in psychologists in Canada.
Which training influenced your suicide risk assessment practice the most?	Understanding what training (and what was it about said training) influenced their practice the most helps us identify where psychologists are learning from and may help us understand where to intervene should we want to change SRA training.
What was it about this training (endorsed option from Q5 here) that made it **the most** influential?	
My graduate training has prepared me to conduct suicide risk assessments	Assesses satisfaction of graduate SRA training. In Dubue and Hanson (2020), all five participants were wholly dissatisfied with their graduate training. Item inspired by and modified from Kerr (2019)
I received sufficient training in suicide risk assessment prior to seeing my first suicidal client.	A lot of psychologists get their suicide risk assessment training "on the job," whereas best practices suggest we should first receive lecture and experiential training (Sommers-Flanagan & Shaw, 2017).
I am confident in my suicide risk assessment practice.	Assesses confidence in SRA practice, which has been reported as low in psychologists (Kleespies et al., 1993) and is positively correlated with increased training (Dexter-Mazza & Freeman, 2003). Modified from Kerr (2019)
I need further training in conducting suicide risk assessments	Measures self-assessment of need for further training. This item will help us understand the desire for more SRA training (which offers opportunity for a follow-up intervention study) Modified from Kerr (2019)

Section 4: Experiences

Section Introduction

Alright! Now, we'd like to know more about your experience conducting suicide risk assessments.

This is the last section before demographics.

Weaving Assessment and Therapy

1. What is your priority when conducting a suicide risk assessment?
   Please be brief with your answer (1-2 sentences).
   a. Short answer

--page break--

Response scale *(Vertical, starting with "Strongly Agree" at the top)*

Strongly Disagree, Disagree, Agree, Strongly Agree
Some response scales will differ; they are listed under the questions.

The order of these questions will be randomized.

Relying on Clinical Intuition

2. I rely on my clinical intuition when determining suicide risk.
3. I trust suicide risk assessment scales or measures when determining suicide risk.
4. Suicide risk assessments help me predict risk of death by suicide.
5. I am knowledgeable in theories of suicide and suicide behaviour.
   a. Very knowledgeable, knowledgeable, somewhat knowledgeable, not at all knowledgeable

Investing in the Suicidal Client

6. I put more effort into my clients who are suicidal.
7. I offer services to suicidal clients not typically offered to non-suicidal clients (e.g., access to a personal phone number, extending sessions).
8. I have broken professional boundaries to prevent someone from dying by suicide.
   a. *Almost always, frequently, sometimes, never.*
9. Treating a suicidal client is more stressful than treating other clients.
10. I worry about my clients with suicidal ideation more than other clients.
11. I feel a sense of urgency when conducting a suicide risk assessment.
12. I feel stressed when conducting a detailed suicide risk assessment.
13. I feel stressed when asking if my client is thinking of suicide.

Fear of Client Suicide Drives SRA

14. I feel powerless in preventing a client's suicide.
15. I fear how I will grieve if my client dies by suicide.
16. Conducting suicide risk assessments helps prevent client deaths by suicide.

17. I know what to do when clients experience clear and imminent suicidal ideation.
18. I fear involving third parties (e.g., police, family member) when my client is experiencing clear and imminent suicidal ideation.

The Pressure of Responsible Caring

19. It is my professional responsibility to prevent my clients from dying by suicide.
20. I fear an improper suicide risk assessment will lead to legal or professional issues if my client dies by suicide.
21. I use suicide risk assessments to protect myself from legal liability.
22. I know what the Code of Ethics (Canadian Psychological Association) says about suicide prevention.
23. Losing a client to suicide means I am a negligent psychologist.

--page break--

24. Have you ever lost a client to suicide?
    a. Yes.
        i. How many clients have you lost to suicide?
        If you are unsure of the exact number, please provide an estimation.
        _____
    b. No.
    c. Prefer not to say.

Section Item Development/Analysis Rationale

Section 3: Experiences *All the themes are taken directly from a previous qualitative study exploring psychologists' experiences conducting suicide risk assessment in Canada* (Dubue & Hanson, 2020)*. This section aims to generalize the findings from this previous study.*	
Weaving Assessment and Therapy	
What is your priority when conducting a suicide risk assessment? *Please be brief with your answer (1-2 sentences).*	The participants in my qualitative study (Dubue & Hanson, 2020) primarily reported how their SRA practice felt like an art, as they wove assessing and treating suicide at the same time. Measuring this factor in a quantitative study comes out as: (a) asking about SRA practices and (b) assessing what is prioritized in such practices. To avoid social desirability bias, I chose to use an open-ended short-answer question. The answers will be analyzed using thematic analysis.
Relying on Clinical Intuition	
I rely on my clinical intuition when determining suicide risk.	Assesses to what degree psychologists "trust their gut", based on a factor and direct quote from Dubue and Hanson (2020).
I trust suicide risk assessment scales or measures when determining suicide risk.	Assesses to what degree psychologists trust SRA scales and measures, based on a factor and direct quote from Dubue and Hanson (2020).
Suicide risk assessments help me predict risk of death by suicide.	This item measures an element of competency in SRA. Growing evidence demonstrates SRAs do not predict death by suicide

	(Franklin et al., 2017). Currently we are unaware if psychologists and other mental health professionals are aware of these recent developments to SRA practice (Sommers-Flanagan & Shaw, 2017). This item will measure the degree to which psychologists are aware of this recent literature.
I know theories of suicide and suicide behaviour.	A chief complaint in the SRA literature is that most researchers and practitioners lack a guiding theory of suicide to base their practice (Kessler et al., 2020). Sommers-Flanagan and Shaw (2017) also argue that "knowledge of theory can help (a) alleviate clinician anxiety, (b) inform clinicians regarding important assessment domains, and (c) provide a framework for deeper understanding of patients who present with suicide-related thoughts and behaviors" (p. 9).
Investing in the Suicidal Client	
I put more effort into my clients who are suicidal.	Based on evidence demonstrating psychologists and clinicians experience more stress working with clients with suicidal ideation (Dubue & Hanson, 2020; Maris, 2019; Pope & Tabachnick, 1993; Shea, 1999).
I offer services to suicidal clients not typically offered to non-suicidal clients. (e.g., access to personal phone number, extending sessions).	Based on evidence demonstrating psychologists often sacrifice their wellbeing (i.e. taking calls in the middle of the night for their suicidal clients) to prevent suicide (Dubue & Hanson, 2020; Reeves & Mintz, 2001).
I have broken professional boundaries to prevent someone from dying by suicide.	
Treating a suicidal client is more stressful than treating other clients.	Based on evidence demonstrating the treatment process (e.g. developing a suicide safety plan, chronic checking in, and in-session stress) is more laborious compared to other clients (Dubue & Hanson, 2020; Hagen et al., 2017).
I worry about my clients with suicidal ideation more than other clients.	Based on evidence demonstrating post-session anxiety and perseveration about the safety of a client with suicidal ideation (Ellis & Patel, 2012), and a direct quote from Dubue and Hanson (2020).
I feel a sense of urgency when conducting a suicide risk assessment.	Based on evidence demonstrating an increase in adrenaline and urgency when immediately confronted with a suicide risk assessment; language stems from a direct quote from Dubue and Hanson (2020).
I feel stressed when conducting a detailed suicide risk assessment.	Based on evidence demonstrating a reactivity in psychologists when conducting a suicide risk assessment. Psychologists who experience anxiety during SRA might react to patients with impaired cognition, leading to a narrow focus understanding and conceptualization of the patients' needs, resulting in a less nuanced understanding of the patient's subjective experience (Jobes, 2000; Large & Ryan, 2014a). "On edge" was previously used for this question instead of "stressed", which is language stemming from a direct quote from Dubue and Hanson (2020).
I feel stressed when asking if my client is thinking of suicide.	Similar to the above question, this question assesses the breadth of reactivity from assessing suicide, but only at the FIRST step in the SRA: asking if they are experiencing suicidal ideation.

Fear of Client Suicide Drives SRA	
I feel powerless in my ability to prevent a client's suicide.	Based on evidence demonstrating clinicians sometimes feel powerless in preventing suicide (Michail & Tait, 2016; Reeves & Mintz, 2001); language stems from a direct quote from Dubue and Hanson (2020).
I fear how I will cope if my client dies by suicide.	Based on evidence demonstrating psychologists fear losing a client to suicide due to the anticipated grief (Dubue & Hanson, 2020; Saigle & Racine, 2018; Skodlar & Welz, 2013).
Conducting suicide risk assessments helps me prevent client deaths by suicide.	Assesses the belief that SRAs have preventive capabilities, which can help reduce the fear of a client's death. This item was developed based on data in Dubue and Hanson (2020) and will measure awareness of novel research highlighting the low effect sizes of SRA treatments/prevention (Kessler et al., 2020).
I know what to do when clients experience clear and imminent suicidal ideation.	Further based on factors/results from Dubue and Hanson (2020), part of the fear experienced by psychologists when conducting suicide risk assessments was not knowing what to do if their client was imminently suicidal.
I fear involving third parties (e.g., police, family member) when my client is experiencing clear and imminent suicidal ideation.	As well, another part of the fear that guides SRA is needing to include third parties in the therapy/safety planning, often by breaking confidentiality (Dubue & Hanson, 2020)
The Pressure of Responsible Caring	
It is my professional responsibility to prevent my clients from dying by suicide.	Assesses psychologists' perceived responsibility and knowledge of their Code of Ethics (CPA, 2017) when working with a client at risk of suicide.
I fear an improper suicide risk assessment will lead to legal issues if my client dies by suicide.	Based on published literature demonstrating healthcare workers fear for being held liable should a client die by suicide (Dubue & Hanson, 2020; Saigle & Racine, 2018).
I use suicide risk assessments to protect myself from legal liability.	Similar to previous questions about psychologists' priorities in SRA, this item addresses the belief that SRAs may be used for legal protection (Dubue & Hanson, 2020; Saigle & Racine, 2018), although no evidence or jurisprudence suggests this is true (Truscott, 2018).
I know what the Code of Ethics (Canadian Psychological Association) says about suicide prevention.	Assesses psychologists' knowledge in their Code of Ethics (CPA, 2017). I'm specifically avoiding measuring competence, but rather getting a sense of how much they think they know.
Losing a client to suicide means that I am a negligent psychologist.	Seeing a client's death by suicide as a failure from the clinician is a common experience (Darden & Rutter, 2011; Dubue & Hanson, 2020). This item measures the degree to which this is perceived.
Have you ever lost a client to suicide?	Chemtob and colleagues' (1989) famously state that losing a client to suicide is an occupational hazard in mental health treatment. Some surveys estimate 5% of predoctoral psychology graduate students (Dexter-Mazza & Freeman, 2003), one in five (McAdams & Foster, 2000) or one in three psychologists (Finlayson & Graetz Simmonds, 2018), and one in two psychiatrists will experience a client's death by suicide. Currently, no data exists on psychologists practicing in Canada.

Section 5: Demographics

Section Introduction

Thanks for your answers.

We're nearly done! Just demographics, next.

Section 4: Demographics

1. What is your gender?
    a. Male
    b. Female
    c. Transgender
    d. Gender Diverse
    e. Other: _____
2. How old are you?
    a. _____
3. Please indicate the highest degree you have attained.
    a. M.Ed.
    b. M.A./M.Sc.
    c. Ed.D.
    d. Psy.D.
    e. Ph.D.
    f. Other: _____
4. What year did you earn this degree?
    a. _____
5. How many years have you practiced as a psychologist?
    a. _____
6. In which provinces or territories are you registered and practice as a psychologist? *(select all that apply)*
    a. British Columbia (College of Psychologists of British Columbia)
    b. Alberta (College of Alberta Psychologists)
    c. Saskatchewan (Saskatchewan College of Psychologists)
    d. Manitoba (Psychological Association of Manitoba)
    e. Ontario (The College of Psychologists of Ontario)
    f. Québec (Ordre des psychologues du Québec)
    g. New Brunswick (College of Psychologists of New Brunswick)
    h. Nova Scotia (Nova Scotia Board of Examiners in Psychology)

   i. Prince Edward Island (Prince Edward Island Psychologists Registration Board)
   j. Newfoundland and Labrador (Newfoundland and Labrador Psychology Board)
   k. Northwest Territories (NWT Professional Licensing)
   l. Nunavut
7. What ethnic/cultural background do you identify most strongly with?
   a. Aboriginal / First Nations / Canadian Indigenous
   b. Asian / Asian Canadian
   c. Biracial / Multiracial
   d. Black / African Canadian
   e. Hispanic / Latinx
   f. Inuit
   g. Métis
   h. White / European Canadian
   i. Other: _____
8. Which of the following best describes your **primary practice setting**?
   a. Armed Forces
   b. Child/Adolescent Psychiatric or Pediatric
   c. Community Mental Health Center
   d. Consortium
   e. General Hospital
   f. Medical School
   g. Outpatient Clinic
   h. Prison/Correctional Facility
   i. Primary Care Network
   j. Private Practice
   k. Psychiatric Unit/Hospital
   l. School/School District
   m. University/College Psychology Department
   n. University/College Counselling Center
   o. Other:
9. Which of the following best describes your **primary theoretical orientation**?
   a. Behavioural
   b. Biological (i.e., Neurological, Chemical)
   c. Cognitive Behavioural
   d. Eclectic
   e. Existential
   f. Feminist
   g. Humanistic
   h. Integrative
   i. Interpersonal
   j. Process-Experiential
   k. Psychoanalytic/Psychodynamic
   l. Systems
   m. Other:
10. Which section(s) of the Canadian Psychological Association are you affiliated with or involved in? Or, which domains pertain most closely to your area of expertise and/or practice? *(select all that apply)*
    a. Indigenous Peoples' Psychology

b. Addictions Psychology
c. Adult Development and Aging
d. Brain and Cognitive Sciences
e. Clinical Psychology
f. Clinical Neuropsychology
g. Community Psychology
h. Counselling Psychology
i. Criminal Justice Psychology
j. Educational and School Psychology
k. Environmental Psychology
l. Extremism and Terrorism
m. Family Psychology
n. Health Psychology and Behavioural Medicine
o. History and Philosophy Section
p. Industrial/Organizational Psychology
q. International and Cross-Cultural Psychology
r. Psychologists in Hospitals and Health Centers
s. Psychology in the Military
t. Psychologists and Retirement
u. Psychopharmacology
v. Quantitative Methods
w. Quantitative Electrophysiology
x. Rural and Northern Psychology
y. Sexual Orientation and Gender Identity
z. Social and Personality Section
aa. Sport and Exercise Psychology
bb. Teaching of Psychology
cc. Traumatic Stress Section
dd. Section for Women and Psychology (SWAP)
ee. Other:

11. Where did you hear about this survey?
(select all that apply)
    a. Canadian Psychological Association Research Portal (e.g., R2P2, CPA Newsletter)
    b. Network or Organization (e.g., Canadian Association for Suicide Prevention)
    c. Peer Referral
    d. Social Media
    e. Other:

Section 6: Follow-up Interview Consent

Perfect! This is all we need for the survey. Thanks!

In a couple of months, **would you like to participate in a 30-minute follow-up phone interview**?

This survey is part of a mixed method study; the interview would help us better understand your survey answers.

a. Yes, I would like to participate in a follow-up phone interview.
    a. Send to Information Letter and Consent Form (below)
b. No.
    a. Send to End of Survey message (below)

Thank you for your interest in our follow-up phone interviews exploring your survey answers!

The purpose of the follow-up phone interviews are to help us understand patterns and insights from the survey results.

Not all interested participants will complete a follow-up interview. You will be informed if you have been, or have not been, selected.

If you agree to participate, you will have an individual phone interview with the Principal Investigator (Jonathan Dubue). Below, you'll be asked for your email which will temporarily connect your survey responses to your interview.

The interview will last 25-30 minutes.

After all the interviews are complete, you will receive a written summary of the themes that emerged across all participants. Here, we are looking for your feedback on how the synthesized themes align with your own individual experience, which should take **5-30 minutes**, depending on how much feedback you wish to provide.

The plan for this study has been reviewed by a Research Ethics Board at the University of Alberta (Pro00105480). If you have questions about your rights or how research should be conducted, you can call (780) 492-2615. This office is independent of the researchers.

The full Information Letter and Consent Form can be found here: bit.ly/SRAInterviewConsent

If you have any further questions, please contact Jonathan Dubue (jdubue@ualberta.ca).

Thank you for your time!

Sincerely,

Principal Investigator:
Jonathan Dubue, M.Ed.
Dept. of Educational Psychology
University of Alberta
jdubue@ualberta.ca

Co-Supervisor:
William Hanson, Ph.D.
Dept. of Psychology
Concordia University of Edmonton
bill.hanson@concordia.ab.ca

Co-Supervisor:
Phillip Sevigny, Ph.D.
Dept. of Educational Psychology
University of Alberta
psevigny@ualberta.ca

- o I agree to participate in the research study described above. I have read and understood the consent form (bit.ly/SRAInterviewConsent) and desire of my own free will to participate.
- o I changed my mind. I do not wish to participate in a follow-up phone interview.

If they agree:

What is your email address?

This email address will be used to connect your survey results to your interview.
Once the interview is complete, your results will be re-anonymized.
Only the Principal Investigator will have access to your identifying information.

_____

Please confirm your email address:

_____

End of Survey Message

Thank you for completing our survey on psychologists' suicide risk assessment (SRA) practices and experiences in Canada. Knowing how psychologists in Canada practice, experience, and are trained in SRA is a fundamental first step in teaching best SRA practices, invariably improving how we attend to our clients experiencing suicidal ideation.

If you would like to connect with the researchers for any reason, including receiving a copy of the final data, **please contact the Principal Investigator (Jonathan Dubue) at** jdubue@ualberta.ca

If you know other psychologists in Canada who would be interested in completing this survey, please share with them the survey link: bit.ly/UofASRASurvey

Thank you again for your participation!

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If you have any concerns about your data, please email jdubue@ualberta.ca with this code: (Unique 4 digit code)

Appendix 3 – Information Letter and Consent Form (Survey)

INFORMATION LETTER and CONSENT FORM
Psychologists' practices and experiences conducting suicide risk assessment in Canada: An explanatory sequential mixed methods study.

[version française ci-dessous]

Principal Investigator:
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Co-Supervisor:
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Phillip Sevigny, Ph.D.
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This Information Letter and Consent Form discusses the
SURVEY DATA COLLECTION portion of the study.

Invitation to Participate: You are being invited to participate in this study examining how registered psychologists in Canada practice and experience suicide risk assessment. We have received your contact information either from the Canadian Psychological Association, your provincial licensing body, or another relevant psychological organization.

Purpose: This survey explores psychologists' practices and experiences in administering suicide risk assessments. Results may inform training, practices, and policy.

Study Procedures: This mixed methods study has two parts: (a) an online survey and (b) follow-up phone interviews. **This information letter and consent form ONLY APPLIES to the survey.** If you agree to participate, you will answer questions about your suicide risk assessment practices, training, and experiences, as well as some demographics. The survey data will be collected on Qualtrics and will be anonymous. At the end of the survey, you may express your interest in participating in a follow-up phone interview.

Duration of Participation: The survey may take 20-30 minutes to complete, depending on the breadth of your responses.

Benefits: Aside from reflecting on your practice, we do not foresee any direct benefit for you as a participant in this study and there is no payment or other compensation for your involvement.

Risks: The potential risk of participating in this study is that you may encounter, or be reminded of, stressful or difficult experiences regarding suicide risk assessment. These risks can be minimized by ensuring you are comfortable with the nature of this survey and connecting with colleagues, professional help, and/or community resources.

Confidentiality & Anonymity: The information that you share will remain strictly confidential and will be used solely for the purposes of this research. Only the research team will have access to the research data. Your Qualtrics data is stored on a Canadian server and is subject to Canadian privacy legislation. Once survey data collection is complete, your responses will be deleted from the Qualtrics servers and stored on a password-protected and encrypted hard drive, which will be in a locked cabinet in a locked room. Identifying information, should it be voluntarily disclosed, will only be seen by the Principal Investigator (Jonathan Dubue) and will be subsequently anonymized. We may also seek to use the results of this study in future research. However, the Research Ethics Board of the University of Alberta will first approve any future use of your data.

Voluntary Participation: You are free to choose not to participate in this study, and you will experience no negative consequences whatsoever as a result. You are also free to discontinue your participation at any time, and you can modify your participation by skipping any questions you would prefer not to answer. If you choose to discontinue participation at a later point in time, you can request that your data be removed from the study and we will gladly remove/destroy your data up until the data is aggregated, which is typically one to three months after your participation.

Dissemination: The data will be used for a Ph.D. dissertation and possibly in conference presentations or journal publications. Only aggregated and anonymized data will be stored indefinitely and reported in publications. At a future date (minimum of 5 years), should the data be deemed unnecessary for retention, the Principal Investigator will destroy the data so that any information cannot be practically read or reconstructed.

Ethics: The plan for this study has been reviewed by a Research Ethics Board at the University of Alberta (Pro00105480). If you have questions about your rights or how research should be conducted, you can call (780) 492-2615. This office is independent of the researchers.

Further Information: If you have any further questions pertaining to your involvement in this study, feel free to contact the Principal Investigator, Jonathan Dubue, using the contact information provided.

Thank you very much once again for your time.

Sincerely,

Jonathan Dubue, William Hanson, & Phillip Sevigny

LETTRE D'INFORMATION et FORMULAIRE DE CONSENTEMENT

Les pratiques et les expériences des psychologues menant une évaluation du risque de suicide au Canada : une étude explicative séquentielle à méthodes mixtes.

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Cette lettre d'information et ce formulaire de consentement portent sur la partie de l'étude relative à la COLLECTE DES DONNÉES DU SONDAGE.

Invitation à participer : vous êtes invité à participer à cette étude qui a pour objet d'examiner la façon dont les psychologues agrées au Canada pratiquent et vivent l'évaluation du risque de suicide. Nous avons reçu vos coordonnées soit par la Société canadienne de psychologie, par votre organisme provincial de réglementation, ou soit par une autre organisation psychologique pertinente.

Objectif : ce sondage explore les pratiques et les expériences des psychologues dans l'administration des évaluations du risque de suicide. Les résultats pourraient impacter la formation, les pratiques et les politiques en lien avec l'évaluation et la prévention du risque de suicide.

Procédures de l'étude : cette étude à méthodes mixtes comprend deux parties : a) un sondage en ligne et b) des entrevues téléphoniques de suivi. **Cette lettre d'information et le formulaire de consentement S'APPLIQUENT UNIQUEMENT au sondage**. Si vous acceptez de participer, vous répondrez aux questions concernant vos pratiques d'évaluation du risque de suicide, votre formation et vos expériences, ainsi que à certaines questions portant sur des données démographiques. Les données du sondage seront recueillies sur une plateforme nommée « Qualtrics » et seront anonymes. À la fin du sondage, vous aurez l'opportunité d'indiquer si vous êtes intéressé à participer à une entrevue téléphonique de suivi. Les entrevues de suivi s'achèveront le 30 juillet, 2021; si vous avez complété le sondage après le 30 juillet, 2021, vous n'aurez pas la possibilité de participer aux entrevues de suivi.

Durée de la participation : le sondage peut prendre 20-30 minutes à compléter, en fonction de l'ampleur de vos réponses.

Avantages : à part l'intérêt d'engager une réflexion sur votre propre pratique, nous ne prévoyons aucun avantage direct pour vous en tant que participant à cette étude et il n'y a aucun paiement ou autre forme de compensation prévus pour votre participation.

Risques : le risque en participant à cette étude est que vous puissiez être confronté – ou être rappelé – à des expériences stressantes ou difficiles concernant l'évaluation du risque de suicide. Ces risques peuvent être minimisés en vous assurant que vous êtes à l'aise avec la nature de ce sondage et en connectant avec des collègues, de l'aide professionnelle ou des ressources communautaires.

Confidentialité et anonymat : les informations que vous partagerez au sein de ce sondage demeureront strictement confidentielles et seront utilisées uniquement dans le cadre de cette recherche. Seule l'équipe de recherche aura accès aux données de recherche. Vos données « Qualtrics » seront stockées

sur un serveur canadien et seront assujetties aux lois canadiennes sur la protection des informations personnelles. Une fois la collecte des données du sondage terminée, vos réponses seront supprimées des serveurs de « Qualtrics » et conservées sur un disque dur crypté et protégé par mot de passe, et qui sera placé dans une armoire verrouillée dans une salle verrouillée. Les renseignements d'identification, s'ils sont divulgués volontairement, ne seront vus que par le chercheur principal (Jonathan Dubue) et seront anonymisés par la suite. Nous pourrions aussi chercher à utiliser les résultats de cette étude dans le cadre de recherches futures. Toutefois, le comité d'éthique de la recherche de l'Université de l'Alberta devra d'abord approuver toute utilisation future de vos données.

Participation volontaire : vous êtes libre de choisir de ne pas participer à cette étude et vous n'en subirez aucune conséquence négative. Vous êtes également libre d'interrompre votre participation à tout moment, et vous pouvez moduler votre participation en sautant les questions auxquelles vous préférez ne pas répondre. Si vous décidez de cesser votre participation à un moment ultérieur, vous pourrez demander que vos données soient retirées de l'étude et nous serons heureux de les supprimer ou de les détruire jusqu'à ce que les données soient regroupées, ce qui se fait généralement un à trois mois après votre participation.

Diffusion : les données seront utilisées pour une thèse de doctorat et, éventuellement, dans des présentations de conférences ou des publications de revues scientifiques. Seules les données regroupées et anonymisées seront conservées indéfiniment et signalées dans des publications. À une date ultérieure (au moins 5 ans), dans l'hypothèse où les données soient jugées inutiles à des fins de conservation, le chercheur principal détruira les données de façon qu'elles ne puissent pas être lues ou reconstituées de façon pratique.

Éthique : le plan de cette étude a été examiné par un comité d'éthique de la recherche de l'Université de l'Alberta (Pro00105480). Si vous avez des questions au sujet de vos droits ou de la façon dont la recherche devrait être menée, vous pouvez appeler le 780-492-2615. Ce bureau est indépendant des chercheurs.

Renseignements supplémentaires : si vous avez d'autres questions concernant votre participation à cette étude, n'hésitez surtout pas à communiquer avec le chercheur principal, Jonathan Dubue, en utilisant les coordonnées fournies.

Nous vous remercions infiniment, à nouveau, pour votre temps.

Sincèrement,
Jonathan Dubue, William Hanson, & Phillip Sevigny

Appendix 4 – Information Letter and Consent Form (Interview)

INFORMATION LETTER and CONSENT FORM
Psychologists' practices and experiences conducting suicide risk assessment in Canada: An explanatory sequential mixed methods study.

Principal Investigator:
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This Information Letter and Consent Form discusses the
INTERVIEW DATA COLLECTION portion of the study.

Invitation to Participate: You have recently completed our survey, which makes you eligible to complete our follow-up interview. Please note, not all interested participants will complete a follow-up interview. You will be informed if you have been, or have not been, selected.

Purpose: The purpose of this follow-up phone interview is to help explain and expand upon your answers in the survey you recently completed measuring psychologists' practices, training, and experiences in administering suicide risk assessments.

Study Procedures: This mixed methods study has two parts: (a) an online survey and (b) follow-up phone interviews. **This Information Letter and Consent Form ONLY APPLIES to the follow-up phone interview**. If you agree to participate, you will have an individual phone interview with the Principal Investigator (Jonathan Dubue). Each interview will be audio recorded and your email will link your survey results to your interview data. However, once interview data collection is complete, linking documents that connect your responses with your identity will be deleted. Interviews will be transcribed and, afterwards, the Principal Investigator will provide you with a written summary of the themes that emerged across all participants. Here, we are looking for your feedback on how the synthesized themes align with your own individual experience.

Duration of Participation: The interview will last 25-30 minutes. You will receive the written summary of the themes several months after your phone interview. Reviewing and submitting your feedback will take anywhere from 5-30 minutes, depending on how much feedback you wish to provide.

Benefits: Aside from reflecting on your practice, we do not foresee any direct benefit for you as a participant in this study and there is no payment or other compensation for your involvement.

Risks: The potential risk of participating in this study is that you may discuss, or be reminded of, stressful or difficult experiences regarding suicide risk assessment. These risks can be minimized as the Principal Investigator will ask very open questions so you can decide how much you want to share.

Confidentiality & Anonymity: All information received will be kept strictly confidential and every effort

will be taken to anonymize your data. By agreeing to participate in this follow-up interview, you will be submitting your contact information (e.g., email contact & phone number) to the Principal Investigator which can be linked to your identity. This contact information will be used to temporarily connect your interview data to your survey responses. Once we have completed the interview, we will anonymize your data by assigning a linked participant ID and scrubbing the interview transcription of any identifying information. This process will happen immediately after the completion of the interview. The anonymized interview data and the connected survey data will be reviewed and analyzed by a team of researchers, all of whom have completed graduate-level ethics training. The raw anonymized data and interpretations will be kept on a password-protected and encrypted hard drive stored in a locked cabinet in a locked room. We may also seek to use the results of this study in future research. However, the Research Ethics Board of the University of Alberta will first approve any future use of your data.

Voluntary Participation: You are free to choose not to participate in this study, and you will experience no negative consequences whatsoever as a result. You are also free to discontinue your participation at any time, and you can modify your participation by skipping any questions you would prefer not to answer. If you choose to discontinue participation at a later point in time, you can request that your data be removed from the study and we will gladly remove/destroy your data up until the data is aggregated or anonymized, which is typically two weeks after your interview.

Dissemination: The data will be used for a Ph.D. dissertation and possibly in conference presentations or journal publications. The anonymized data will be kept indefinitely. We may use direct anonymized quotes from the interview. At a future date (minimum of 5 years), should the data be deemed unnecessary for retention, the Principal Investigator of this project will destroy the data so that any information cannot be read or reconstructed.

Ethics: The plan for this study has been reviewed by a Research Ethics Board at the University of Alberta (Pro00105480). If you have questions about your rights or how research should be conducted, you can call (780) 492-2615. This office is independent of the researchers.

Further Information: If you have any further questions pertaining to your involvement in this study, feel free to contact the Principal Investigator, Jonathan Dubue, using the contact information provided.

Thank you very much once again for your time.

Sincerely,
Jonathan Dubue, William Hanson, & Phillip Sevigny

Appendix 5 – Recruitment Letter

Psychologists' Suicide Risk Assessment Practices and Experiences in Canada

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[Message en français qui suit]

I am inviting psychologists in Canada to participate in a survey about their **practices and experiences conducting suicide risk assessments** for my Ph.D. dissertation research project.

This anonymous survey is expected to take **20-30 minutes** to complete.

Survey link: bit.ly/UofASRASurvey

I would also appreciate it if you could

share this survey with other psychologists in Canada!

This study has been approved by the University of Alberta Research Ethics Board 2 (Pro00105480) and is on the CPA's Research Portal.

I appreciate your consideration and hope this message finds you well!

Principal Investigator:
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DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

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Pratiques et expériences des psychologues en matière d'évaluation du risque suicidaire au Canada

Nous vous invitons, en votre qualité de psychologue, à participer à notre **sondage concernant vos pratiques et expériences en matière d'évaluation du risque suicidaire**, pour ma thèse de doctorat à l'Université de l'Alberta.

Ce sondage anonyme devrait vous prendre **20-30 minutes** à compléter.

Lien vers le sondage : bit.ly/UofASRASurvey

Je vous serais également très reconnaissant de bien vouloir **partager ce sondage avec d'autres de vos collègues psychologues au Canada !**

Cette étude a été approuvée par le comité d'éthique de la recherche de l'Université de l'Alberta (Pro00105480) et se trouve sur le portail de recherche de la SCP.

J'apprécie votre considération et j'espère que ce message vous trouvera en bonne santé !

Chercheur principal :
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Appendix 6 – French Canadian version of the Survey

Pratiques et expériences des psychologues en matière d'évaluation du risque suicidaire au Canada

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DÉBUT DU SONDAGE

Nous vous remercions de l'intérêt que vous portez à notre sondage sur les pratiques et les expériences des psychologues en matière d'évaluation du risque suicidaire !

Le but de ce sondage est de mieux comprendre comment les psychologues effectuent des évaluations du risque de suicide et comment cela affecte leur pratique. L'objectif est d'utiliser ces données pour orienter la formation, la pratique et les politiques concernant l'évaluation du risque de suicide au Canada.

Le sondage devrait prendre <u>20-30 minutes</u> à compléter.

Le sondage est anonyme et vous pouvez le quitter à tout moment.

Le plan de cette étude a été examiné par un comité d'éthique de la recherche de l'Université de l'Alberta (Pro00105480). Si vous avez des questions au sujet de vos droits ou de la façon dont la recherche devrait être menée de façon générale, vous pouvez composer le 780-492-2615. Ce bureau est indépendant des chercheurs de cette étude.

Vous trouverez la lettre d'information complète et le formulaire de consentement ici : LIEN ICI

Si vous avez d'autres questions, veuillez communiquer avec Jonathan Dubue (jdubue@ualberta.ca).

Merci de votre attention !

Cordialement,

Chercheur principal :
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University of Alberta
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Co-Superviseur :
William Hanson, Ph.D.
Dept. of Psychology

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Co-Superviseur :
Phillip Sevigny, Ph.D.
Dept. of Educational Psychology
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- J'accepte de participer à l'étude de recherche décrite ci-dessus. J'ai lu et compris le formulaire de consentement (bit.ly/SRASurveyConsent) et souhaite de mon plein gré y participer.
- Je ne consens pas à participer à cette étude.

Section 0 : Critères d'inclusion

Section Introduction

Alors, commençons !

Cela devrait prendre 20-30 minutes ou moins.

Tout d'abord, assurons-nous que vous êtes un bon candidat(e) pour ce sondage.

---

1. Je suis un(e) psychologue inscrit(e) ou titulaire d'une licence qui exerce actuellement au Canada et qui suis en règle auprès de mon organisme d'agrément provincial
    a. Oui
    b. Non
2. J'ai effectué des évaluations du risque de suicide* auprès de clients/patients au cours des 10 dernières années.
   *l'acte de discuter, de déterminer ou de surveiller le risque d'une personne de se suicider.
    a. Oui
    b. Non

Si l'une des réponses aux questions ci-dessus est « non », le participant est dirigé vers une page différente.

Pour être inclus dans cette étude, **vous devez** être un(e) psychologue agréé(e) au Canada et être en règle auprès de votre organisme d'agrément provincial **ET** avoir effectué des évaluations du risque de suicide auprès de clients/patients au cours des 10 dernières années.

Si vous avez fait une erreur en répondant aux questions concernant les critères d'inclusion et que vous répondez réellement aux critères ci-dessus, veuillez retourner à la page précédente en cliquant sur le bouton « back (retour) », situé ci-dessous.

Si vous ne répondez pas aux critères, nous vous remercions sincèrement de votre temps et de votre considération ! Vous pouvez maintenant terminer ce sondage.

Si les deux réponses sont « oui », le participant est dirigé vers une autre page contenant les questions suivantes :

3. Quand approximativement avez-vous effectué votre dernière évaluation du risque de suicide ?
    a. Au cours des 7 derniers jours
    b. Au cours du dernier mois
    c. Au cours des 6 derniers mois
    d. Au cours de la dernière année
    e. Au cours des 5 dernière années
    f. Au cours des 10 dernière années

4. Dans quelle mesure êtes-vous intéressé(e) par l'étude et la pratique de l'évaluation du risque de suicide ?
    a. Extrêmement intéressé(e)
    b. Très intéressé(e)
    c. Modérément intéressé(e)
    d. Un peu intéressé(e)
    e. Pas du tout intéressé(e)

Section 1 : Pratiques

Section Introduction

Très bien. Parlons maintenant des pratiques d'évaluation du risque de suicide.

Les questions suivantes sont importantes. Veuillez prendre votre temps en répondant aux questions dans cette section.

---

5. Avec quelle fréquence faites-vous des évaluations du risque de suicide ?
    a. Rarement (avec un faible pourcentage de mes clients)
    b. Parfois
    c. Fréquemment
    d. Presque toujours (avec un pourcentage important de mes clients)
6. Lors des premières séances avec de nouveaux clients, à quelle fréquence évaluez-vous le risque de suicide ?
    a. Rarement (avec un faible pourcentage de mes clients)
    b. Parfois
    c. Fréquemment
    d. Presque toujours (avec un pourcentage important de mes clients)
7. Lors d'une séance de psychothérapie individuelle, un(e) client(e) vous dit qu'il envisage se suicider.

    Étape par étape, comment procéderiez-vous ?

    Veuillez décrire votre processus dans son intégralité.
    Il s'agit de la question la plus importante du sondage.
    Vous pouvez utiliser des points d'énumération si vous préférez.

    a. Réponse ouverte détaillée

Section 2 : Formation

Section Introduction

Merci de nous aider à mieux comprendre vos pratiques quant à l'évaluation du risque de suicide.

Parlons maintenant de votre formation.

---

1. Avez-vous reçu une formation* portant sur l'évaluation du risque de suicide ?
   *La formation, telle que définie dans cette étude, s'agit d'une activité d'apprentissage de quelqu'un qui possède des connaissances ou des compétences en lien avec le sujet.
   a. Oui
   b. Non
2. Si oui, où avez-vous reçu la formation ?
   (Sélectionnez toutes les réponses qui s'appliquent)
   a. Centre de crise/ligne de détresse
   b. Travail bénévole ou salarié (autre que dans un centre de crise/ligne de détresse)
   c. Première ou deuxième année d'études supérieures (p. ex. cours, stage)
   d. Troisième, quatrième, cinquième, sixième année ou plus d'études supérieures (p. ex. cours, stage)
   e. Stage(s) à temps plein ou à temps partiel (p. ex. stage de maîtrise, stage pré-doctoral)
   f. Perfectionnement professionnel, ateliers ou formation continue
   g. Apprentissage autonome ou informel
   h. Autre : _____
   i. Aucune de ces réponses (je n'ai pas reçu de formation sur l'évaluation du risque de suicide)
      i. Si cette réponse est sélectionnée, diriger le participant à la question 9 de ce bloc.

--page break--

3. Quel type de formation avez-vous reçu chez [each individually endorsed location]
   a. Éducatif (p. ex., conférences, séminaires)
   b. Animé (p. ex., scénarios de jeux de rôles)
   c. Sous supervision (p. ex., formation menée par le superviseur clinique)
   d. Académique (p. ex., analyse documentaire, lecture)
   e. Besoin d'en dire plus ?
4. ***If "Professional development, workshops, or continuing education" was endorsed:***
   En ce qui concerne le perfectionnement professionnel, les ateliers ou la formation continue :
   a. Quelle(s) formation(s) avez-vous suivie(s) ? _____
   b. Qu'est-ce qui vous a fait suivre ces formations ?
5. ***If "Self-directed or informal learning" was endorsed:***
   En ce qui concerne l'apprentissage autonome ou informel:

a. Quel type d'apprentissage autonome ou informel avez-vous complété ?
b. Qu'est-ce qui vous a fait poursuivre un apprentissage autonome ou informel ?

--page break--

6. Quelle formation **a le plus** influencé votre pratique d'évaluation du risque de suicide ?
7. (If any option other than Q2 c, d, or e) Quand avez-vous reçu cette formation ?
    a. Avant vos études supérieures
    b. Pendant vos études supérieures
    c. Suite à vos études supérieures
8. Qu'est-ce qui vous a **le plus** influencé durant cette formation (SELECTED OPTION) ?
    Veuillez répondre brièvement (1-2 phrases).

(Fortement en désaccord, en désaccord, d'accord, fortement d'accord)

9. Ma formation d'études supérieures m'a préparé à effectuer des évaluations du risque de suicide.
10. J'ai reçu une formation suffisante sur l'évaluation du risque de suicide avant de rencontrer mon premier client suicidaire.
11. J'ai confiance en ma pratique d'évaluation du risque de suicide.
12. J'ai besoin d'une formation supplémentaire sur la conduite des évaluations du risque de suicide.

Section 3 : Expériences

Section Introduction

Alors ! Nous aimerions maintenant en savoir davantage sur votre expérience dans la conduite d'évaluations du risque de suicide.

Il s'agit de la dernière section avant les données démographiques.

---

1. Quelle est votre priorité lorsque vous effectuez une évaluation du risque de suicide ?
   Veuillez répondre brièvement (1-2 phrases).

--page break--

Relying on Clinical Intuition

2. Je me fie à mon intuition clinique pour déterminer le risque de suicide.
3. Je fais confiance aux échelles ou aux mesures d'évaluation du risque de suicide lorsque je détermine le risque de suicide.
4. Les évaluations du risque de suicide m'aident à prédire le risque de décès par suicide.
5. Je suis bien informé(e) quant aux théories du suicide et du comportement suicidaire.
   a. *Très informé*(e)*, informé*(e)*, assez bien informé*(e)*, pas du tout informé*(e)

Investing in the Suicidal Client

6. Je déploie plus d'efforts auprès de mes clients qui sont suicidaires.
7. J'offre des services aux clients suicidaires qui ne sont généralement pas offerts aux clients non suicidaires (*p. ex. : accès à un numéro de téléphone personnel, prolongation des séances*).
8. Il m'est arrivé de dépasser les limites professionnelles pour empêcher quelqu'un de se suicider.
   a. *Presque toujours, fréquemment, parfois, rarement.*
9. Traiter un client suicidaire est plus stressant que traiter d'autres clients.
10. Je me préoccupe davantage de mes clients qui ont des idées suicidaires que de mes autres clients.
11. J'ai un sentiment d'urgence lorsque je conduis une évaluation du risque de suicide.
12. Je me sens stressé(e) lorsque je conduis une évaluation détaillée du risque de suicide.
13. Je me sens stressé(e) quand je demande à mon client s'il pense au suicide.

Fear of Client Suicide Drives SRA

14. Je me sens incapable de prévenir le suicide d'un client.
15. Je crains comment je vais vivre mon deuil, si mon client meurt en se suicidant.
16. Mener des évaluations du risque de suicide aide à prévenir le suicide des clients.
17. Je sais ce qu'il faut faire lorsque des clients présentent des idées suicidaires claires et imminentes.
18. Je crains de faire appel à des tiers (p. ex., la police, un membre de la famille) lorsque mon (ma) client(e) éprouve des idées suicidaires claires et imminentes.

The Pressure of Responsible Caring

19. Il s'agit de ma responsabilité professionnelle d'empêcher mes clients de se suicider.
20. Je crains qu'une évaluation inappropriée du risque de suicide puisse entraîner des problèmes juridiques ou professionnels si mon client meurt en se suicidant.
21. J'utilise les évaluations du risque de suicide pour me protéger en rapport à ma responsabilité légale.
22. Je suis conscient et je comprends ce que dit le Code d'éthique (de la Société canadienne de psychologie) au sujet de la prévention du suicide.
23. Perdre un client en raison d'un suicide signifie que je suis un psychologue négligent.

--page break--

24. Avez-vous déjà perdu un(e) client(e) par suicide ?
    a. Oui
        i. Combien de client(e)s avez-vous perdu(e)s par suicide ?
        Si vous n'êtes pas sûr du nombre exact, veuillez fournir une estimation.
    b. Non
    c. Je préfère ne pas le dire.

Section 4 : Démographiques

Section Introduction

Merci pour vos réponses.

Nous avons presque terminé ! Il nous reste uniquement les données démographiques.

Section 4 : Démographiques

1. Quel est votre genre ?
    f. Homme
    g. Femme
    h. Transgenre
    i. Genre divers
    j. Autre :
2. Quel âge avez-vous ?
    b. _____
3. Veuillez indiquer ci-dessous quel est le diplôme universitaire le plus élevé que vous avez obtenu.
    g. M.Ed.
    h. M.A./M.Sc./M.C.
    i. Ed.D.
    j. Psy.D.
    k. Ph.D.
    l. Autre : _____
4. En quelle année avez-vous obtenu ce diplôme ?
    b. _____
5. Combien d'années avez-vous pratiqué en tant que psychologue ?
    a. _____
6. Dans quelles provinces ou territoires êtes-vous inscrit et pratiquez-vous à titre de psychologue ? *(Sélectionnez toutes les réponses qui s'appliquent)*
    a. Colombie-Britannique (College of Psychologists of British Columbia)
    b. Alberta (College of Alberta Psychologists)
    c. Saskatchewan (Saskatchewan College of Psychologists)
    d. Manitoba (Psychological Association of Manitoba)
    e. Ontario (The College of Psychologists of Ontario)
    f. Québec (Ordre des psychologues du Québec)
    g. Nouveau-Brunswick (Collège des psychologues du Nouveau-Brunswick)
    h. Nouvelle écosse (Nova Scotia Board of Examiners in Psychology)
    i. Île-du-Prince-Édouard (Prince Edward Island Psychologists Registration Board)

   j. Terre-Neuve et le Labrador (Newfoundland and Labrador Psychology Board)
   k. Terriroires du Nord-Ouest (NWT Professional Licensing)
   l. Nunavut
7. À quel groupe ethnique/culturel vous identifiez-vous le plus ?
   a. Autochtone / Premières nations / Autochtone canadien
   b. Asiatique / Canadien d'origine asiatique
   c. Biraciale / Multiraciale
   d. Noir / Afro-Canadien
   e. Hispanique / Latinx
   f. Inuits
   g. Métis
   h. Blanc / Canadien d'origine européenne
   i. Autre :
8. Lequel des énoncés suivants décrit le mieux **votre pratique principale** ?
   a. Les forces armées
   b. Psychiatrie ou pédiatrie enfant/adolescent
   c. Centre communautaire de santé mentale
   d. Le consortium
   e. Hôpital général
   f. École de médecine
   g. Clinique externe
   h. Prison / établissement correctionnel
   i. Réseau de soins primaires
   j. Pratique privée
   k. Unité psychiatrique / hôpital
   l. École / Secteur scolaire
   m. Département de psychologie universitaire / collégiale
   n. Centre de counseling universitaire / collégial
   o. Autre :
9. Lequel des énoncés suivants décrit le mieux votre **orientation théorique principale** ?
   a. Comportementale
   b. Biologique (c.-à-d. neurologique, chimique)
   c. Cognitivo-comportementale
   d. Éclectique
   e. Existentielle
   f. Féministe
   g. Humaniste
   h. Intégrative
   i. Interpersonnelle
   j. Processus expérientiel
   k. Psychanalytique/Psychodynamique
   l. Systèmes
   m. Autre :
10. À quelle(s) section(s) de la Société canadienne de psychologie êtes-vous affilié(e) ou impliqué(s) ? Ou, quels domaines concernent le plus étroitement votre domaine d'expertise ou votre pratique ?
    (Sélectionnez toutes les réponses qui s'appliquent)
    a. Psychologie des peuples autochtones

b. Psychologie de la dépendance
c. Développement adulte et vieillissement
d. Cerveau et sciences cognitives
e. Psychologie clinique
f. Neuropsychologie clinique
g. Psychologie communautaire
h. Psychologie du counseling
i. Psychologie et justice pénale
j. Psychologie éducationnelle et scolaire
k. Psychologie de l'environnement
l. Extrémisme et terrorisme
m. Psychologie de la famille
n. Psychologie de la santé et médecine du comportement
o. Histoire et philosophie de la psychologie
p. Psychologie industrielle et organisationnelle
q. Psychologie internationale et interculturelle
r. Psychologues en milieux hospitaliers et en centres de santé
s. Psychologie du milieu militaire
t. Psychologues et la retraite
u. Psychopharmacologie
v. Méthodes quantitatives
w. Électrophysiologie quantitative
x. Psychologie des communautés rurales et nordiques
y. Orientation sexuelle et identité sexuelle
z. Psychologie sociale et de la personnalité
aa. Psychologie du sport et de l'exercice
bb. Enseignement de la psychologie
cc. Stress traumatique
dd. Section : Femmes et psychologie
ee. Autre :

11. Où avez-vous entendu parler de ce sondage ?
(Sélectionnez toutes les réponses qui s'appliquent)
    a. La Société Canadienne de Psychologie (p. ex. R2P2, bulletin du SCP)
    b. Réseau ou organisation (p. ex. l'Ordre des psychologues du Québec)
    c. Référence par les pairs
    d. Médias sociaux
    e. Autres :

End of Survey Message

Nous vous remercions d'avoir répondu à notre sondage sur les pratiques et les expériences des psychologues en matière d'évaluation du risque de suicide (ERS) au Canada. Savoir comment les psychologues au Canada pratiquent, vivent et reçoivent une formation sur les ERS est une première étape fondamentale dans l'enseignement des meilleures pratiques d'ERS, améliorant invariablement la façon dont nous nous occupons de nos clients qui vivent des idées suicidaires.

Si vous souhaitez communiquer avec les chercheurs pour une raison quelconque, y compris pour recevoir une copie des données finales, **veuillez communiquer avec le chercheur principal (Jonathan Dubue) par courriel** (jdubue@ualberta.ca)

Si vous connaissez d'autres psychologues au Canada qui aimeraient répondre à ce sondage, veuillez leur faire part du lien vers le sondage : bit.ly/UofASRASurvey

Merci encore de votre participation !

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Si vous avez des inquiétudes concernant vos données, veuillez envoyer un courriel à jdubue@ualberta.ca en y attachant ce code : (Unique 4-digit code)

Appendix 7 – Coding System for Question 7 in Practices

Category	Code Options	Description of Code Options
General Practices *These categories are broad descriptions of the participants' SRA practice that typically require a full read and interpretation for proper coding.*		
Response Quality	Limited Appropriate Thorough	Some of the answers appeared intentionally bare and may have not been fully descriptive of the participant's SRA practice. **Limited**: Usually one to two sentences, does not mention key common SRA practices (e.g., risk factors) **Appropriate:** At least two sentences and typically contains more than two practices. Note, if the participant endorses a standardized protocol, it is automatically appropriate. **Thorough:** Typically five or more sentences and includes a significant amount of detail.
Structure of SRA?	Standardized SRA Structured SRA Fluid SRA	**Standardized SRA:** a scale, measure, system, or protocol is primarily used when conducting an SRA, where the delivery is standardized. **Structured SRA**: participant primarily relies on their own SRA knowledge and conducts SRAs that have an order/structure, but are not named or manualized. **Fluid SRA:** assesses key suicide markers where the order is adaptive to client disclosure and emerging insights through the assessment. The participant mentions avoiding checklists, that it's not "step-by-step" with each client, or that the SRA is woven throughout the session.
Focus of SRA?	Information-Gathering SRA Therapeutic SRA	**Information-Gathering SRAs**: focused on gathering risk and protective factor information, often to inform the development of a safety plan (Finn, 2007). **Therapeutic SRAs:** prioritize the therapeutic opportunities in SRA, often using humanistic skills while gathering risk information, and developing a safety plan. The differentiation is based on Finn & Tonsager's (1997) original descriptions.
First step?	Assess/Information Exploration Connection/Empathy	*These codes were collaborative and iteratively developed during analysis.* **Assess/Information:** asks about risk or a risk-related item.

	Self-Reflection	**Exploration:** asks for more information, gives space for client to expand on suicidality **Connection/Empathy:** humanistic skills (e.g., validation) **Self-Reflection:** typically a reminder to self-regulate and prepare for the SRA.
Specific Practices *These categories are specific "checklist" SRA practices coded as a binary. If the practice was described at least once in the answer, it was coded positively.*		
The response options below are all "yes" or "no"		
Uses a humanistic skill	Mentions using a therapeutic skill that is related to treating the client's distress.	
Collaborates with client	Involving the client in the SRA process or any mention of collaboration.	
Uses a specific SRA protocol	Coded positively if they endorse using the scale/protocol natively or if their practice is based on that scale/protocol. * if Yes, follow-up with "which one?"	
Assesses risk factors	Mentions anything about asking about risk factors or things that increase risk.	
Assesses protective factors	Mentions anything about asking about protective factors or things that decrease risk.	
Assesses cultural/spiritual factors?	Asks about culture, spirituality, or the client's interpretation of what happens after death.	
Asks/acknowledges suicide driver(s)	Asks/assesses underlying causes of suicidal ideation.	
Assesses plan	Asks about the client's plan to die by suicide.	
Assesses suicidal thoughts	Asks about suicidal thoughts (frequency, content, severity).	
Discusses confidentiality	Any mention of consent, confidentiality, or limits to confidentiality.	
Discusses ambivalence	Explain or describes ambivalence, such as asking if the client wants to live, die, or end their pain.	
Asks about reasons for living	Includes any related variation (e.g., keeps you alive, why haven't you chosen suicide yet).	
Uses a suicide prevention contract	Any variation of the no-suicide contract is included (e.g., no-harm contract, verbal agreement). This does NOT include signing a safety plan.	
Connects client with internal supports	Internal supports are personal strengths, coping skills, any "internal" resource. Note: for a positive code the participant must ***connect*** the client with these supports, not just ask about them (which would just be a protective factor assessment).	
Connects client with familiar external supports	External supports are family, friends, peers, organizations, or other interpersonal resources ***from which they have historically received support.*** Note: for a positive code the participant must ***connect*** the client with these supports, not just ask about them (which would just be a protective factor assessment). Further, the external support cannot be a novel organization (e.g., distress line they have not previously connected with).	

Provides an emergency/24hr contact	Mentions or refers to an emergency help-line.
Provides out-of-session personal contact	Mentions or refers to contact that can be made outside of session (specifically related to helping prevent suicide).
Considers hospitalization	Mentions hospitalization as an option in their suicide prevention process.
Develops a safety plan	Mentions safety planning.
Differentiates risk levels	Provides different plans or processes according to an assessed "level of risk" (e.g., high, medium, low, imminent risk).
Engages in any hope-building	Uses the word hope or uses any hope-building skill (e.g., asking what gives them hope). This can include asking about reasons for living, but only if used as an intervention (e.g., some participants "determined if [their client] has something to live for", which is not hope-building but assessing.
Discusses any follow-up	Any check-in that occurs after the session, including future sessions.

Appendix 8 – Coding System for Questions 4, 5, and 8 in Training

Question	Response Option
Regarding professional development, workshops, or continuing education, what training(s) did you complete?	1. Suicide-Related Community Organization
	2. Private Workshop
	3. University Workshop
	4. Hospital Rounds
	5. Brief Lecture
	6. Theoretical Orientation Training
	7. Specific Scale Training
	8. CAMS
	9. ASSIST
	10. Academic Conference
	11. Do Not Remember
Regarding self-directed or informal learning, what kind did you complete?	1. Readings
	2. Online (e.g., videos, webinars)
	3. Consultation
	4. Specific SRA protocols
	5. Organization guidelines
	6. Twitter
	7. Podcast
	8. Newsletter
What made you pursue [professional development / self-directed training]?	1. High-risk clients
	2. Required by work
	3. Self-interest
	4. Professional responsibility
	5. Increase competence and skill
	6. Decrease anxiety
	7. Refresher/staying-up-to date
	8. Recent loss to suicide
	9. Reducing liability
	10. For supervisee training/leadership
	11. Fill training gap
	12. Part of research project
What was it about this training that made it the most influential?	1. Relevant to client work
	2. Experiential
	3. Practicable
	4. Timely
	5. Self-reflective
	6. Consultation/Supervision
	7. Expert facilitator
	8. Frequent practice
	9. Intensive and detailed
	10. Personalized
	11. Empirical
	12. Only training conducted
	13. Did not answer the question

Appendix 9 – Coding System for Question 1 in Experiences

Code	Response Option	Description of Responses & Rationale
First Priority?	Assessing Risk	Explicitly mentions assessing risk or imminency.
	Safety	Mentions anything related to safety (e.g., keep client safe, avoid harm).
	Therapy/Treatment	Anything related to the treatment of suicidality (e.g., encourage hope, give space client to talk).
	Connection/Empathy	Anything related to connection or rapport (e.g., maintain therapeutic relationship, ensure they feel comfortable with my questions).
Second Priority? *If none leave blank*	Same response set as above.	

Appendix 10 – Follow-Up Research Question Development

"Follow-up explanation variant":

Representative sampling with follow-up questions based on specific findings that a representative sample could answer.

"The typical psychologist practicing SRA"

Research Questions:

(1) What are psychologists' practices of SRA?

(2) How are psychologists trained in SRA?

(3) How do psychologists experience SRAs?

(4) How do the interviews explain the survey results?

   a. How do psychologists choose their SRA practice?

   b. How and when do psychologists become confident in their SRA practice?

   c. What are psychologists' reasons for using or not using SRA scales or measures?

   d. How do psychologists understand the role of hospitalization in preventing suicide?

   e. How and when do psychologists believe they should be trained in suicide prevention?

   f. How do psychologists understand the etiology of suicide?

   g. What makes working with suicidal clients stressful to psychologists?

   h. How do psychologists understand their ethical responsibility regarding suicide prevention?

Qualitative Follow-Up Questions

FURQ	Quantitative Findings	Interview Questions	Decision Rationale
How do psychologists choose their SRA practices?	76% use structured SRAs, 18% use standardized SRAs, and 7% use fluid SRAs. 86% use information-gathering SRAs whereas 14% practices therapeutic SRAs	How did you choose your SRA practice?	Given the survey asks about the most influential training, we know what makes training good but not how they've decided on their SRA practice. *Answers to this question will help elucidate the training-to-practice pipeline, giving insight into psychologists' decision-making when adopting SRA and management practices.*
How and when do psychologists become confident in their SRA practice?	95% are confident in their SRA practice. 62% believe their graduate-level SRA prepared them to conduct SRA.	When did you become confident in your SRA practice? What contributed to your confidence?	Previous evidence suggested psychologists lack confidence in their SRA practice (Kleespies et al., 1993), which is not true in this study. *This is an important metric, as confidence is positively correlated with increased training* (Dexter-Mazza & Freeman, 2003) *and may therefore be understood as a marker to no longer seek continuing education in SRA.*
What are psychologists' reasons for using or not using SRA scales or measures?	74.6% of participants did not cite any evidence-based measure (includes safety planning, risk evaluation). 72% do not use any SRA scales or measures. 59% rely on their clinical intuition when determining suicide risk 55% trust SRA scales or measures when determining suicide risk.	Can you tell me more about your decision [to include] / [to not include] a scale or measure in your SRA practice?	Most SRA scales or measures are poor predictors of suicide deaths and risk (Kessler et al., 2020). Although many psychologists practice without using these scales or measures, clinical judgements, or unstructured SRA interviews, are also no better predictors of suicide than are social, historical, or clinical variables (Large et al., 2011). *This question will further elucidate psychologists' decision pathway to selecting their main practices*.
How do psychologists understand the role of hospitalization in preventing suicide?	55% recommend, endorsed, or mentioned hospitalization in their SRA practice. 81% do not fear involving third parties when their client is experiencing clear and imminent suicidal ideation.	How do you decide when or whether to hospitalize a suicidal client?	Hospitalization, when compared to outpatient treatment, after a suicide attempt was no less likely to prevent a subsequent death by suicide (Steeg et al., 2018), and, in another study, was found to increase the risk of continued suicide behaviours for up to a year

	97% know what to do when clients experience clear and imminent suicidal ideation.		(Ichimura et al., 2019). Further, hospitalizations have increased patient risk of suicide death, iatrogenic harm, and nosocomial symptoms (DeCou & Schumann, 2018; Large et al., 2014; Ward-Ciesielski & Rizvi, 2020). Further, high-risk interventions in suicide prevention often involve a third party, where confidentiality and, in some cases, autonomy and liberty, are compromised for the sake of perceived safety (McKernan et al., 2018). These invariably harm the therapeutic alliance created between the clinician and the client, which can lead to attrition and mistrust in the clinician and mental health care, ultimately, barring critical access to treatment and prevention (Hom et al., 2019; Siegel, 1979).
How and when do psychologists believe they should be trained in suicide prevention?	59% believe their graduate-level SRA prepared them to conduct SRA. 50% believe they received sufficient SRA training prior to seeing their first suicidal client. 54% believe they need further training in SRA. 23% did not receive any graduate-level SRA training. 65% received their most influential training after graduate school, 20% during, and 15% before. Most influential training: 32% professional development, 21% full/part-time internship, and 12% crisis center.	When did you feel ready to work with suicidal clients? Are there any ways your graduate SRA training could have been improved?	Most clinicians agree that they are not sufficiently trained in SRA and suicide prevention (Audouard-Marzin et al., 2019; Cramer et al., 2013; Dubue & Hanson, 2020; Jahn et al., 2016, 2017; Sommers-Flanagan & Shaw, 2017), even if their SRA competency is deemed appropriate (Kerr, 2019). This is in part a graduate training problem, as it often lacks in meaningful engagement with suicide theory and experiential practice (Liebling-Boccio & Jennings, 2013). *This is a critical question. Understanding how psychologists view and understand SRA training will help us better intervene with training for current and future psychologists.*
How do psychologists understand the etiology of suicide?	60% of psychologist do not assess for the cause(s) of suicidal ideation/drivers to suicide.	What are your thoughts about why people become suicidal?	Novel and increasingly contemporary SRA (and management) approaches center treatment around suicide drivers, or the causes of suicide (Swift et al., 2021). As well, Truscott (2021)

	88% agree that conducting SRAs helps prevent client deaths by suicide. 57% agree SRAs help them predict the risk of death by suicide.		details the ethical and practical imperative of treating the factors related to suicidality. *Asking about their understanding of suicide etiology will provide insight into their understanding of suicide as a symptom rather than a disease.*
What makes working with suicidal clients stressful to psychologists?	77% find treating a suicidal client is more stressful than treating other clients. 19% feel stressed when asking if their client is thinking of suicide. 40% feel stressed when conducting a detailed SRA. 73% worry about their clients with suicidal ideation more than other clients 57% feel a sense of urgency when conducting an SRA. 63% put more effort into their clients who are suicidal. 42% offer services to suicidal clients not typically offered to non-suicidal clients. 81% never broke professional boundaries to prevent someone from dying by suicide.	[if agree] What makes working with suicidal clients more stressful? [if disagree] What makes working with suicidal clients just as stressful as other clients?	For most clinicians, SRAs are the most stressful and challenging responsibility (Maris, 2019; Shea, 1999), often due to lacking time, believing nothing can be done, and fearing litigation (Ellis & Patel, 2012; Reeves & Mintz, 2001). Given the existential nature of suicide, clinicians risk debilitating death anxiety when treating suicide-related trauma (Cureton & Clemens, 2015) as their absolute greatest clinical fear is that of a client's death by suicide (Pope & Tabachnick, 1993). As well, psychologists conducting SRAs reported fear guides their SRA practice, as they experience a culture of surveillance and aim to avoid litigation by intervening regardless of client autonomy (Dubue & Hanson, 2020). *Psychologists who experience anxiety during SRA might react to patients with impaired cognition, leading to a narrow focus understanding and conceptualization of the patients' needs, resulting in a less nuanced understanding of the patient's subjective experience* (Jobes, 2000; Large & Ryan, 2014a). *This is a critical question.*
How do psychologists understand their ethical responsibilities regarding suicide prevention?	68% fear an improper SRA will lead to legal or professional issues if their client dies by suicide. 80% know what the Code of Ethics says about suicide prevention	What are your ethical responsibilities when a client brings up brings up suicidal ideation? [if unanswered] How does this affect your	An emerging finding on SRA experiences is that healthcare workers fear for being held liable should a client die by suicide (Dubue & Hanson, 2020; Saigle & Racine, 2018).

	58% believe it is their professional responsibility to prevent clients from dying by suicide 68% use SRAs to protect themselves from legal liability. 42% offer services to suicidal clients not typically offered to non-suicidal clients. 88% do not mention any discussion of the limits of confidentiality in their SRA.	practice with suicidal clients?	*Given a majority of psychologists believe SRAs may be used for legal protection, despite there existing no evidence, case law, or jurisprudence to support this* (Truscott, 2018)*, it is important to see how psychologists rationalize the liability threat to inform how to better educate psychologists on their actual ethical responsibilities.*

*Note. Some of the quantitative findings in this section were calculated without the final sample and are therefore outdated. However, these were the findings used to develop the qualitative questions and, in comparison to the quantitative findings of the final sample, are sufficiently similar (i.e., within a couple of percentage points).

Rejected Follow-Up Qualitative Questions

FURQ	Quantitative Findings	Exclusion Rationale
How do psychologists treat suicidality?	44% of psychologists connect their clients with internal supports (hope-building, anxiolytic skills, strengths) 39% of psychologists demonstrated some evidence of humanistic skills (e.g., active listening, validation). 100% of participants, when faced with a suicidal client, do some sort of risk assessment.	It appears psychologists believe SRAs are well indicated when working with a suicidal client. However, a missing piece in the quant findings is what psychologists do after the assessment. Or, said differently, we do not know what psychologists believe is remedial to suicidality. *This is a good question, but it's too big. It's another study on its own. As well, I get what I need from this question from the "Etiology" question anyways.*
How do psychologists explain the lack of culturally competent SRAs?	99% of participants do not assess for cultural factors. 90% of the sample is European-Canadian/white	Chu and colleagues (2017) did a whole paper on this, so there's a good amount of literature to compare to. *The same authors also did a whole paper on why psychologists aren't doing culturally-informed SRAs. Although this would provide supplemental and comparable evidence, it is not robust enough of an inquiry for a true comparison with Chu's paper, nor do I expect psychologists to answer with much nuance outside of "I didn't know I should."*
How do psychologists know when to stop assessing for suicide risk (over-assessment)?	76% use structured SRAs, 18% use standardized SRAs, and 7% use fluid SRAs. 86% use information-gathering SRAs 95% assess for a plan 75% assess for risk factors 74% assess for thoughts of suicide 63% assess for protective factors	Jobes (2020), in discussing the recommendations of the National Action Alliance of Suicide Prevention, discusses the importance of not "over-assessing" suicide risk. In this context, this means not repeating the same assessments across sessions. However, given the structured yet unstandardized nature of most SRAs practiced in Canada, I wonder how psychologists know when enough is enough, both within an SRA and between sessions/SRAs. *Although this is a good and interesting question, it is not so well-evidenced that is must be answered immediately, or in this study.*
How do psychologists explain the purpose of assessing for suicide in first sessions/intakes?	77% of participants "frequently" or "almost always" assess for suicide risk on the first clinical interview.	Recent aggregated evidence shows universal screening has almost no effect on suicide prevention, despite considerable financial and logistical costs (Nestadt et al., 2020). Although the benefits relative to the costs of

		intervention for SRA can be higher than treating everyone or treating no one (Kessler et al., 2020), SRAs, as they stand, are generally poor predictors of deaths by suicide and weak predictors of suicide attempts. *This question is strong and would highlight the importance of knowledge translation in suicide prevention. But the answer to this RQ is predictable (e.g., I do it to keep clients safe, it is important to know for tx planning). This would be a good pre-post question after they've been informed of the novel contraindication.*
How informed are psychologists about contraindications in suicide assessment and management?	11% of psychologists use suicide prevention/no suicide contracts.	No-suicide contracts are ineffective and relationally harmful (Edwards & Sachmann, 2010; Range et al., 2002). *Although it's important to know what not to do, no-suicide contracts are the only clear contraindication in the literature. Increasing evidence points to hospitalization, IG-only SRA, and unstandardized clinical interviews as worthless or harmful, these recommendations have not yet made their way into practice. I may get some interesting humanistic answers (e.g., never say there's more to live for). This is neat, but I don't think it requires an empirical validation right now.*
How do psychologists see the relevance of suicide theory to suicide prevention practice?	67% say they are knowledgeable or very knowledgeable in suicide theory.	A chief complaint in the SRA literature is that most researchers and practitioners lack a guiding theory of suicide to base their practice (Kessler et al., 2020). Sommers-Flanagan and Shaw (2017) also argue that "knowledge of theory can help (a) alleviate clinician anxiety, (b) inform clinicians regarding important assessment domains, and (c) provide a framework for deeper understanding of patients who present with suicide-related thoughts and behaviors" (p. 9). *This might still be an interesting question to include. It wouldn't take long to answer and I could get a better sense of how they understand the theory-practice relationship specifically regarding suicide.*
What are psychologists'	57% fear how they will cope if their client dies by suicide.	Psychologists often fear losing a client to suicide due to the anticipated grief (Dubue

experiences of losing a client to suicide?	27% of participants have lost at least one client to suicide 3% believe they are negligent psychologists if they've lost a client to suicide. 17% feel powerless in preventing a client's suicide.	& Hanson, 2020; Saigle & Racine, 2018; Skodlar & Welz, 2013), made worse by feeling powerless about its prevention (Michail & Tait, 2016; Reeves & Mintz, 2001). *This continues to be an interesting question, but I would rather have depth in my qual interviews than breadth. Losing a client to suicide is a big inquiry, and may derail the conversation outside of my main goal of answering my RQs.*
What is it about SRAs that psychologists believe prevents suicide?	88% agree that conducting SRAs helps prevent client deaths by suicide. 57% agree SRAs help them predict the risk of death by suicide.	*This question has been integrated into the "Etiology" question. After I ask about the etiology, I will ask how they believe this informs their use of SRA for suicide prevention.*
What do psychologists understand about the intersection of hope and suicidality?	29% of participants mentioned, discussed, or connected their clients with hope and hope-building.	*An interesting question for a different researcher and study.*
How do psychologists alter their treatment plans when suicidal risk is high? Low?	65% differentiate suicide risk levels in their SRA.	*Somewhere, someone would likely be interested in doing a secondary analysis on the quant SRA practices data to see how psychologists differ in this practice. That somewhere is not here and that someone is not me.*
How does supervision impact psychologists' SRA practices and experiences?	Unfortunately, there's no directly significant data here, but this might be a nice follow-up during the interviews.	*An interesting question for a different researcher and study.*
What are psychologists' experiences of asking peers for assistance with a suicidal client?	Again, no direct quant evidence to back this up, but would be interesting to see how they ask for support.	Brown and colleagues (2017) has a factor on this in their multimethod study of school psychologists. *Unless the participant brings this up themselves, this isn't big enough to be its own RQ.*
How do psychologists reconcile the differences in: - Confident practitioners (95%) who want more training (54%) - Most influenced by post-graduate training (57%), although grad training was sufficient (59%).		*The issue with these questions is that I'd need to sample folks who represent these competing dichotomies. Explanations for these results may also be estimated through demographic analysis (e.g., practitioners are generally confident, but younger practitioners want more training?) Further, each individual factor (e.g., practitioner*

-	Those who fear liability (66%), but also claim to know what the Code of Ethics says about suicide prevention (80%)	*confidence, timing of graduate training, and the interplay of liability and practice) are all being assessed as their own RQ.* *These could be included as follow-ups for participants who do endorse diametric opposites.*

*Note. Some of the quantitative findings in this section were calculated without the final sample and are therefore outdated. However, these were the findings used to develop the qualitative questions and, in comparison to the quantitative findings of the final sample, are sufficiently similar (i.e., within a couple of percentage points).

Appendix 11 – Interview Protocol

Semi-structured interview protocol

Remind participant of confidentiality and review consent. Ask for verbal consent to proceed.

Ask if they have reviewed their survey answers prior to the interview.

Let's start with getting a better understanding of your suicide risk assessment practices.

1. How did you choose your suicide risk assessment practice?
2. When did you become confident in your suicide risk assessment practice?
    a. What contributed to your confidence?

The next few questions are about specific suicide risk assessment and management practices.

3. [no scale] Can you tell me more about your decision not to include a scale or measure in your suicide risk assessment practice?
   [yes scale] Can you tell me more about your decision to include a scale or measure in/as your suicide risk assessment practice?
4. How do you decide when or whether to hospitalize a suicidal client?

Now let's talk about your training.

5. When did you feel ready to work with suicidal clients?
6. Are there any ways your graduate SRA training could have been improved?

These last few questions are about your experiences with suicide and suicide risk assessment.

7. What are your thoughts about why people become suicidal?
8. [if agree working with suicidal clients is stressful] What makes working with suicidal clients more stressful?
   [if disagree] what makes working with suicidal clients just as stressful as other clients?
9. What are your ethical responsibilities when a client brings up suicidal ideation?
    a. [if unanswered] How does this affect your practice with suicidal clients?

And to wrap us up.

10. Is there anything else from the survey you would like to comment on?

Appendix 12 – Email Communications with Interview Participants

1st communication – sent to all participants who indicated an interest on the survey

Subject: 30 minute Follow-Up Phone Interviews - Suicide Risk Assessment Practices and Experiences

Hi there!

Thank you for taking my survey on your suicide risk assessment practices and experiences. It was a humbling and incredible pleasure to read your response!

At the end of the survey, you may recall indicating your interest in a 30-minute follow-up phone interview. This interview will help me better explain and understand your survey answers, which is part of my mixed methods design.

Are you still interested in this 30-minute follow-up phone interview? I am hoping to conduct the interviews within the next six weeks.

I am aiming for a representative sample of psychologists in Canada. As such, even though you may be interested, I may not select you for the interviews. I will let you know either way.

Once I hear of your continued interest, I'll be in touch with more details! Of course, there is absolutely no pressure to participate in the interview; it is expected that some folks have changed their mind!

For your information, I've attached the Information Letter and Consent Form.

Looking forward to hearing your response!

ATTACHED INFORMATION LETTER AND CONSENT FORM

--

2nd communication – if interested and fits representativeness

[Provide personalized follow-up message]

To make the booking process easier, please indicate when you'd like to interview through this link: [booking link]

I will be asking broad questions about your suicide risk assessment practices, training, and experiences. There is no need to prepare anything for this interview. However, you're welcome to review your survey responses, which I've attached in this email.

ATTACHED PERSONAL AND ANONYMOUS SURVEY RESPONSE

The interview will be conducted over the phone. I'll be calling the phone number you provided to me over the booking site.

And, as a reminder, any identifying information will be quickly anonymized once the audio is transcribed, and considerable effort has been taken to protect your privacy. Only I will know your identity at any point in this study.

One to two months after the interview, I'll be sending you a summary of the themes and findings. Here, I'm looking for your feedback on how the synthesized themes align with your own individual experience. This will take a minimum of five minutes, depending on how much feedback you wish to provide.

Again, my deepest and sincerest thanks for your help with this study! The privilege to conduct this study and hear your experiences is not lost on me, and I hope you find some personal benefits to your participation!

Looking forward to our talk!

--

3rd communication – Post-interview

Hi NAME!

Thanks again for the interview today! I really liked [note about the interview]

As a reminder, I'll be sending you a synthesized summary of the themes from the interviews. In this synthesized member check, I'm looking for your feedback on how your individual experiences match up with the themes across participants. This should take a minimum of five minutes, but please take as much time as you'd like!

You'll receive this document before the end of August!

Thanks again for your time and effort! I know you know the value of research, but I cannot understate the inspiration I feel to see your commitment. I'm looking forward to sharing with you the results!

Well wishes,

--

If not selected but indicated interest

Hi NAME!

Thanks for your interest! It's such a treat seeing so many people interested in this project!
As I'm aiming to get a representative sample of psychologists in Canada, I've had to be selective in who I chose to interview. And although I would honestly love to interview everyone (and I am serious about that), I've met my quota and **I'm not currently recruiting for interviews.**

That said, it has already happened that some of my participants can no longer make an interview, so there may still be a chance I do contact you. However, if you don't hear from me before the end of August, there's a good chance I've wrapped up this part of the study.

Of course, I would still be pleased to help however I can regarding suicide risk assessment practices. **If you'd like, it would be a pleasure to share with you the study results and some relevant readings**, once I compile everything.

Thanks again for your time. I am still hoping I can contact you for an interview!

Take care,

Appendix 13 – Rapid Assessment Process Exemplar

Individually-Coded Summary Table

RQ 3: What are psychologists' reasons for using or not using SRA scales or measures?

Participant	Answer
1 (1788)	Structured SRA (Does not use scale) - Qualitative data is perceived as more valid/scales are unreliable - Influenced by setting (e.g., requires a risk categorization in hospital)
2 (2455)	Structured SRA (Does not use scale) - Previous training/work sites didn't use a scale - Is self-directing training to see if there's value in changing practice
3 (3298)	Standard SRA (Uses a scale) - Employer mandates the use of an SRA scale (no choice)
4 (3494)	Fluid SRA (Does not use scale) - Questions are used from scales but adapted into interventions/fluid with therapeutic practice. - Avoids medicalizing/labeling/risk categorization.
5 (4203)	Fluid SRA (Does not use scale) - Questions are used from scales (memorized) but the scales themselves detract from the conversation/harms the client connection
6 (5049)	Structured SRA (Does not use scale) - "Wasn't part of my training, so it wasn't part of my practice"
7 (5126)	Structured SRA (Uses a scale) - Part of post-doc training (DBT)
8 (7234)	Structured SRA (Does not use scale) - Scales don't give the full qualitative picture
9 (7428)	Structured SRA (Uses a scale) - Mandated by work
Notes	Those who don't use scales cite the unreliability of them/the richness in qualitative data, find they get in the way of client connection, or they simply weren't told/educated about them. Those who use scales cite employer or workplace mandates or dedicated training that utilizes them (DBT & L-RAMP).
Theme(s)	**Mandated by setting** *However, those that used scales also cite how they did not have much of a choice to use them or not. The work setting often demanded a specific scale be used by psychologists as to achieve the above efficacies.* **Scales are effective in institutions** (theme name from TA analysis) *Those that used scales discussed their utility in interdisciplinary or complex health settings, as they help avoid chronic reassessment by other clinicians, facilitates communication, and shares a common language and risk categorization/decision-tree.* **Scales obstruct client connection** (theme name from TA analysis) *Those who did not use SRA scales argued that they detract from connecting with the client, which is important as there is a richness of qualitative data that is gathered through a scale-less clinical interview.*

Combined review of summaries

RQ 3: What are psychologists' reasons for using or not using SRA scales or measures?

Participant	**Principal Investigator**	Co-Investigator
1 (1788)	Structured SRA (no scale) - Qualitative data is perceived as more valid / scales are unreliable - Influenced by setting (e.g., requires a risk categorization)	No Scale - Feels fairly arbitrary because there isn't a way to know how accurate you're being - Suicide ideation is fluid and can change quickly - The context of the client's life is more important
2 (2455)	Structured SRA (No scale) - Previous training/work sites didn't use a scale - Is self-directing training to see if there's value in changing practice	No Scale - Training sites didn't use them, - Participant believes that she wants to use best practices which they have found doesn't require a formal scale
3 (3298)	Standard SRA (Yes scale) - Employer mandates the use of an SRA scale (no choice)	Yes Scale - Wasn't necessarily their choice as much as their employer - Does appreciate that they did a literature review to choose a scale - The scale isn't perfect in their eyes but works for the use they need
4 (3494)	Fluid SRA (No scale) - Questions are used from scales but adapted into interventions/fluid with therapeutic practice. - Avoids medicalizing/labeling/risk categorization.	No Scale - Sees the value in not "labelling" clients and working from a humanistic/strength-based approach
5 (4203)	Fluid SRA (No scale) - Questions are used from scales (memorized) but the scales themselves detract from the conversation/harms the client connection	No Scale - Believes that it "detracts" from conversing and connecting with the client - Impacts the therapeutic bond
6 (5049)	Structured SRA (No scale) - Wasn't part of my training, so it wasn't part of my practice	No Scale - Wasn't part of their training so it didn't become part of their practice
7 (5126)	Structured SRA (Yes scale) - Part of post-doc training (DBT)	Yes Scale - Use it because it was part of their DBT training - Helps to decide next steps
8 (7234)	Structured SRA (No scale)	No Scale

	- Scales don't give the full qualitative picture	- Finds the scales are more specific to demographics and don't attend to the individual and their circumstances
9 (7428)	Structured SRA (Yes scale) - Mandated by work	Yes Scale - Uses the scale because it is mandatory in their place of work - Also chooses to use it within the larger discussion with the client and not in a checklist format
Notes	Those who don't use scales cite the unreliability of them/the richness in qualitative data, find they get in the way of client connection, or they simply weren't told/educated about them. Those who use scales cite employer or workplace mandates or dedicated training that utilizes them (DBT & L-RAMP).	Consider past code that some people did not know SRA scales existed. Some participants discussed the code "perceived as uncompassionate" and "used for liability insurance".
Theme(s)	**Mandated by setting** *However, those that used scales also cite how they did not have much of a choice to use them or not. The work setting often demanded a specific scale be used by psychologists as to achieve the above efficacies.* **Scales are effective in institutions** *Those that used scales discussed their utility in interdisciplinary or complex health settings, as they help avoid chronic reassessment by other clinicians, facilitates communication, and shares a common language and risk categorization/decision-tree.* **Scales obstruct client connection** *Those who did not use SRA scales argued that they detract from connecting with the client, which is important as there is a richness of qualitative data that is gathered through a scale-less clinical interview.*	**Emphasizing person-first data** *Participants who did not use SRA scales endorsed the importance of using qualitative and contextual data to better understand their client's risk of suicidality. This qualitative inquiry, they believed, was not well represented on SRA scales or measures.* **Training and setting determined decision** *Participants discussed how their training or their workplace mandated or did not use scales; whatever practice they were exposed to was the one they adopted. Notably, participants detailed how scales were most effective in interdisciplinary and custodial health settings.*

Exemplar of final themes developed through RAP

RQ 3: What are psychologists' reasons for using or not using SRA scales or measures?	**Mandated by setting** *However, those that used scales also cite how they did not have much of a choice to use them or not. The work setting often demanded a specific scale be used by psychologists as to achieve the above efficacies.* **Scales are effective in institutions** *Those that used scales discussed their utility in interdisciplinary or complex health settings, as they help avoid chronic reassessment by other clinicians, facilitates communication, and shares a common language and risk categorization/decision-tree.* **Scales obstruct client connection** *Those who did not use SRA scales argued that they detract from connecting with the client, which is important as there is a richness of qualitative data that is gathered through a scale-less clinical interview. They prioritize, instead, person-first data gathering.*

*Note. These are not the final themes we decided on. We iterated on these themes across multiple meetings and incorporated feedback from supervisors and through the synthesized member check.

Appendix 14 – Synthesized Member Check Document

Synthesized Member Check

Psychologists' Practices and Experiences of Suicide Risk Assessment (SRA) in Canada

Thank you for your time in reviewing these themes!

This should take 5-30 minutes, depending on the breadth of feedback you wish to provide.

Methodology

After the survey, the research team parsed through the quantitative data and came up with follow-up research questions, eight of which were selected for the interviews. The interviews were analyzed by a team of qualitative researchers using both inductive and deductive methodologies, then aggregated through discussion into the following themes.

Instructions

Please review the themes and answer the following questions:

1. Does this match your experience?
2. What would you change or add?

You're welcome to answer these questions either

a) directly in the email response or
b) by annotating this document.

RQ 1: How do psychologists choose their SRA practice?	
SRA practices are haphazardly chosen	Participants noted their SRA practices were seldom "chosen", rather they adopted the practices of their practicum and internship supervisors, developed their own from client feedback, embraced a workplace-specific practice, or formed one from post-graduate self-directed professional development. The varied nature of how suicide assessment and prevention practices are adopted showcase that most training in the area is informal, unintentional, and eclectic.

RQ 2: How and when do psychologists become confident in their SRA practice?	
Confidence comes years after graduate school	All participants except one, who experienced an early client death by suicide in their masters, noted they were confident after several years in dedicated psychotherapy practice.
Confidence from practice with feedback	What helped their confidence was repeated practice, often with high-risk clients, and receiving feedback from supervisors, peers, and other interdisciplinary team members. Importantly, some participants intentionally avoided overconfidence, knowing they could be confident in the process of prevention but not in the outcome.
RQ 3: What are psychologists' reasons for using or not using SRA scales or measures?	
Implications of standardized SRA	The choice to use SRA scales was dependent on participant's views on the utility and constraints of SRA standardization. Those that use SRA scales appreciated how standardization facilitates communication and interdisciplinary client care in institutional or custodial settings. Those who do not use them report SRA scales detract from client connection, preferring clinical interviews focused on qualitatively contextualizing their client's distress.
Training and setting determined decision	Superseding opinions on standardization, participants identified that their training or workplace better determined their SRA scale usage. Some health settings mandated scales, whereas other participants were never trained in SRA scale use.
RQ 4: How do psychologists understand the role of hospitalization in preventing suicide?	
Hospitalization is an invasive last resort to prevent physical harm	Psychologists hospitalize/refer to hospital when they assess their clients to be in imminent physical danger. This decision is based on suicide risk categorizations, evidence of rigid thinking, or an inability to commit to other safety measures. Participants see hospitalization as a last resort, only used when all other safety options have been exhausted. They described how hospitalization is a cost-benefit decision, weighing the benefit of physical safety against the emotional harm of violating their right to autonomy. Some clinicians noted it takes confidence and risk tolerance to resist referring clients to hospitals.

RQ 5: How and when do psychologists believe they should be trained in suicide prevention?	
Psychologists are ready for SRA practice after graduate training	Six of the nine participants indicated they were ready to work with suicidal clients only after their graduate training, whereas the others detailed how in-vivo supervision and experiential training helped them feel ready, earlier.
Supervised experiential practice is essential to SRA training	In describing their preparedness, nearly all participants highlighted how they learned suicide assessment and prevention from their practicum or internship supervisors. They also noted how in-vivo feedback (peer and supervisor) and experiential practice (e.g., role-plays) were important to getting ready to see suicidal clients.
Suicide assessment and prevention is a core competency that should be mandatory learning in graduate school	Participants further elaborated that their graduate training seldom included intentional suicide assessment or prevention training, despite it being a critical feature in psychologists' practice. As SRA practice is inconsistent across psychologists, they recommended that graduate training include dedicated coursework prior or during practica.
RQ 6: How do psychologists understand the etiology of suicide?	
Suicidality comes from hopelessness, because the pain never ends	All participants explicitly endorsed hopelessness as the main etiology of suicide. Psychologists noted how clients are ambivalent towards death, instead desire to end a never-ending pain, punctuated by feeling stuck, purposeless, or isolated. Some participants conceptualized this hopelessness as cognitive or emotional dysregulation. Suicidality, in this frame, is a call for help.
RQ 7: What makes working with suicidal clients stressful to psychologists?	
The pressure of responsible caring	For most psychologists, it is the inability to guarantee their client's physical safety that makes working with suicidality stressful. This stress is proportional to the client's perceive risk level, as higher risk levels pressure psychologists to risk the client's autonomy and dignity by enacting paternalistic safety measures (e.g., hospitalization). Further, participants identified suicidal clients require more administrative resources, emotional boundaries, and intentionality in their treatment.

RQ 8: How do psychologists understand their ethical responsibility regarding suicide prevention?	
Ethical obligation to assess and prevent suicide, at the cost of autonomy	Most psychologists identified their ethical obligation when a client brings up suicide is to complete an assessment for the purposes of identifying how best to keep them safe from physical harm. In this assessment, psychologists aim to balance safety and privacy, although are disproportionately influenced by their responsibility to prevent suicidal death.

Thank you again for your time! It's folks like you that grow our profession towards more ethical and empirical practices.

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Appendix 15 – Pillar Integration Process Example and Modification

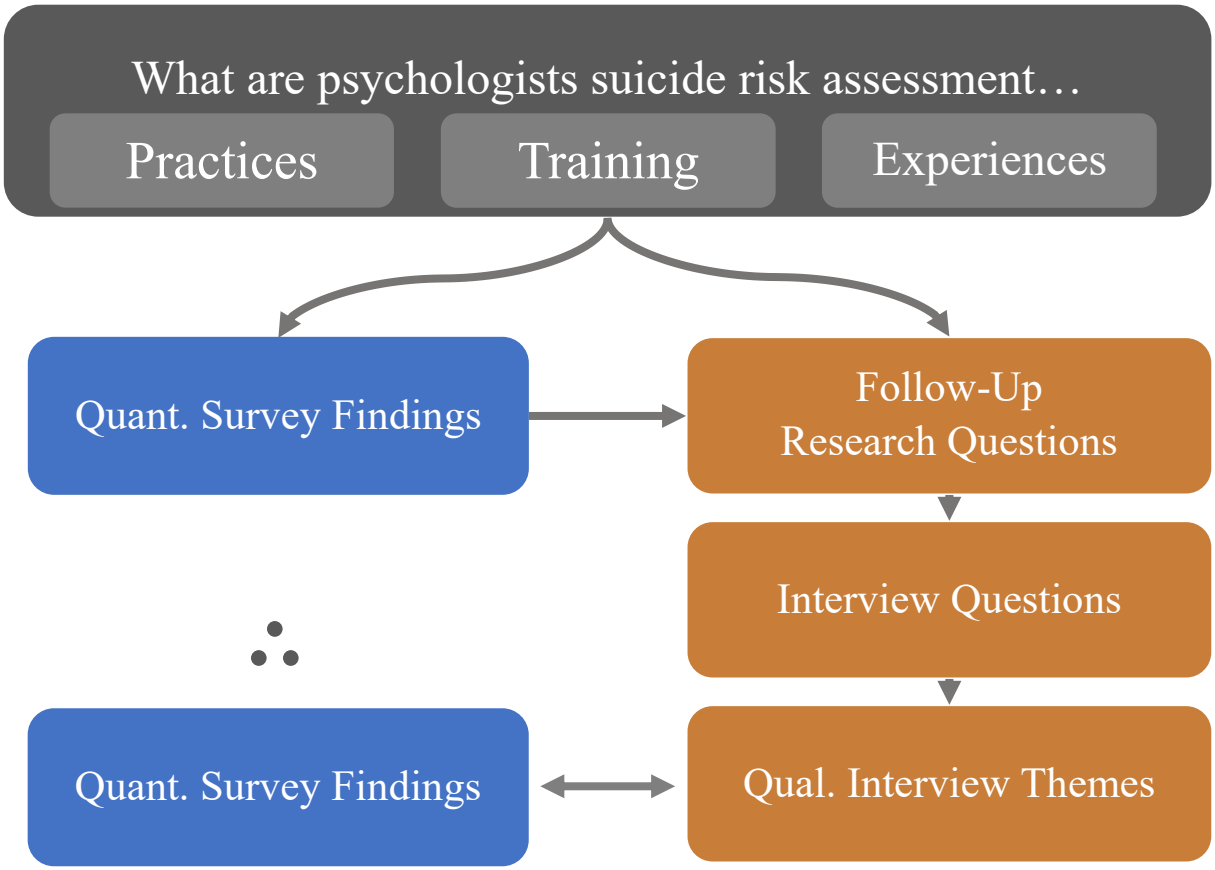
The following example of a single pillar theme originates from table 2 in R. E. Johnson et al. (2019), which reproduces data from a Wellbeing Mentor Intervention Study.

Case: Wellbeing Mentor Intervention				
QUANT data	QUANT categories	Pillar building themes	QUAL categories	QUAL codes
23% of participants were aged 11 or 12 and were excluded from the analysis	Evaluation fidelity: Didn't follow flow chart of exclusion criteria	Hierarchy, positioning, approaches to leadership	When mentors were not adequately supported, they struggled to manage workloads	*"The mentors themselves didn't have the authority. They are seen as auxiliary support staff. So in terms of the pecking order, the hierarchical place of them in the schools…I don't know if teachers were receptive to what they were saying."*
3/8 schools (37.5%) completed academic achievement outcome requests	Partial data collected on academic achievement and was different for each school		Context and autonomy between school, staff, and mentors	

The following example is how we modified the PIP table to better represent the unidirectionality of the sequential-explanatory mixed method design.

Research Question	**Survey Findings**	**Interview Themes**	**Integrated Conclusions**
What are psychologists' practices of SRA?	76% use structured SRAs, 18% use standardized SRAs, and 7% use fluid SRAs. 86% use information-gathering SRAs whereas 14% practices therapeutic SRAs	SRA practices are haphazardly chosen	SRA practices are structured but unstandardized, focused on gathering information. Psychologists are confident in these practices but have not intentionally chosen them. They are products of training, work environment, or theoretical orientation beliefs.
	95% are confident in their SRA practice. 62% believe their graduate-level SRA prepared them to conduct SRA.	Confidence comes years after graduate school Confidence from practice with feedback	

Appendix 16 – Pillar Integration Process: Matching (modified)



Appendix 17 – Researcher-as-Instrument for the Co-Investigator

My family has been touched by the impacts of mental health concerns many times, which has helped to reinforce my desire to work as a psychologist. However, it was in early adulthood that I became more sharply aware and concerned with the issue of how and why individuals come to die by suicide. A close family friend was struggling with severe mental health concerns, including trauma, self-harm, periods of mania, and suicide attempts. I was immediately concerned with how to help with empathy, and how to support my other family members. During this time, I used the skills I was learning through volunteering at the MacEwan Peer Support Centre. I drew upon my skills to practice empathy, genuineness, and non-judgement to talk to her about their struggles, mediate conversations among my family members, and encourage them to seek therapy.

My understanding of suicide risk assessment has come from my graduate training as well as external training in the area. Philosophically, I believe that it is not the job of the psychologist to convince the client to keep living no matter the circumstances. Rather, we are to come alongside clients in recognizing their own autonomy over their life, both to be able to pursue healing without suicide, and to acknowledge that their life is ultimately theirs to embrace or end. We have a responsibility to maximize benefit and minimize risk to our clients which includes proper treatment for things which may increase likelihood of suicidal ideation such as mood disorders, trauma, relationship issues and the like. However, I also believe that the practice of suicide risk assessment is often steeped in legal protection of the psychologist rather than what is in the best interests of the client.